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ABSTRACT

This report includes papers dealing with various facets of the library's role in filling the lay health education need and the appropriate responses to that need as conceived by the conference participants; the total content reflects the input from medicine, nursing, social work, community medicine, law, voluntary health agencies and national institutions, as well as from librarianship. In addition to papers presented by members of an interdisciplinary symposium on the issues, problems, and opportunities of health education, the report contains information on the following: (1) alternative patterns of cooperation in a variety of settings; (2) library materials supporting health education; (3) legal, ethical, and social dimensions of health education; and (4) establishing and maintaining health resource centers. An evaluation and a discussion of the conferences are included, and appendices provide a program of the institute, a list of participants, a pre-measurement instrument, a post-measurement instrument, and a communication to the National Commission on Libraries and Information Science. Tables illustrate a number of points brought out at the conference. (FM)

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PATIENT/HEALTH EDUCATION: THE LIBRARIAN'S ROLE

Proceedings of an Invitational Institute
February 5-9, 1979

Given under the auspices of
Wayne State University
College of Education
Division of Library Science

Edited by

Miriam T. Larson, Associate Professor
Division of Library Science
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Division of Library Science
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PREFACE

The increasing interest evinced by laymen in access to health information and the concern which they have for more personal knowledge about both good health and ill health, has found the profession of librarianship incompletely prepared to assist. The fact that libraries are unsure of the appropriate response to the consumer demand for such information neither answers nor removes the pressure from the public. Nor does failure to have a health information referral system generally available take away the commitment which librarians have, as a part of the very nature of their profession, to provide information to whomever seeks it. Neither medical nor public librarians are intimately associated with the primary health care team and frequently have little knowledge of the kinds of health information which are valid and useful for particular individuals or situations.

The Institute on Patient/Health Education: The Librarian's Role was conceived as a way to facilitate a direct dialog between professional librarians, from a wide variety of libraries, and representatives from other health-related professions and agencies. It was anticipated that, from such a dialog, a clearer definition would evolve of ways in which libraries might respond to the demand for a public equipped, through education and information, to assist in the health endeavor.

Funded by the United States Office of Information, the Institute was held at Wayne State University on February 5-9, 1979. The Proceedings include both the papers prepared for the Institute dealing with various facets of the lay health education need and the appropriate responses to that need as conceived by the conference participants. The total content reflects the input from medicine, nursing, social work, community medicine, law, voluntary health agencies and national institutions as well as from librarianship. It is hoped that the publication of these Proceedings will act as a catalyst to stimulate a concerted effort by the library profession and the various health professions to develop a more active and significant partnership in the dissemination of health information to the public.

As Director of the Institute, I wish to make particular acknowledgment of the invaluable contributions to the conference which were made by Professor Genevieve Casey of the

Division of Library Science, Wayne State University, the Associate Director of the Institute, and by James Williams II, Librarian of the Shiffman Medical Library of Wayne State University and Director of the KOM Regional Medical Library. The expertise, experience, and cooperation which each gave to the endeavor contributed immeasurably to the very high degree of involvement and enthusiasm evidenced by the participants.

I wish to extend my sincere thanks to Dr. Robert Booth, Director of the Division of Library Science at Wayne State University, and to my colleagues on the faculty for their support and encouragement of this program. I also wish to acknowledge my indebtedness to Barbara Coe Johnson, Director of Libraries, Harper Hospital, for the opportunity of including the Harper Hospital Medical Library as a part of the field observation arranged for the Institute participants and for her willingness to discuss at length the issues and points which needed to be addressed during the Institute. Such cooperation is an invaluable asset.

A special word of appreciation and commendation is reserved for the participants who came from all parts of the country to become deeply involved in developing plans for cooperative efforts, both with libraries and with other health agencies, designed to offer to the layman the information he seeks. The hours were long and the effort to coalesce diverse viewpoints and experiences into documents which could be presented to the health care world for examination was frequently arduous. The statements, as presented in the Proceedings, and the efforts which have subsequently been made by the participants to disseminate what was learned at the Institute, speak clearly to the dedication of the library profession to providing relevant and needed information services.

It is my sincere conviction that the degree of participation, the investment of talent, and the genuine concern which was evidenced by this group of dedicated professionals--resource personnel and participants alike--will promote a quality of response to all health-related information needs which will guarantee that the profession of librarianship will be prepared to respond effectively to the health information needs of the layman.

June 1979 Miriam T. Larson

INTRODUCTION

Miriam T. Larson

Public access to health information, presented in terms which can be understood by the layman, has become an urgent demand and one which must be addressed. While traditionally the physician has been, and continues to be, the person primarily responsible for informing a patient about his diagnosis, treatment, and prognosis, the hospital too has a responsibility and the patient has a "right to know". Those persons who do not have close affiliations with either personal physicians or with hospitals also have a need for knowledge which will allow them to make reasonable decisions about their personal welfare. The public, whether "well" or "unwell" has not been hesitant to say that this access to medical information has been less than complete.

Certainly many professions and agencies have a very real involvement in making persons aware of health hazards and health benefits. The large numbers of voluntary health agencies which are supported by public subscription, the multiple health professions concerned with the welfare and the treatment of the ill, and the service professions devoted to freely providing information of all kinds attest to our basic concern. It is, rather, that we have failed to synchronize our efforts into an effective force capable of making health knowledge readily available, understandable, and useful to the layman.

Several points become immediately obvious as the desire by the public for more and better health education is examined:

1. The demand of the public for health information is real, legitimate, and of considerable magnitude.

2. The task of informing not only the patient but also the general public becomes a burden which is arduous beyond the capacity of the physician alone to bear.

3. Other professions and agencies must and can assist within the potential and capabilities of each.

4. Cooperative efforts among a variety of health information providers would allow each to serve at the most effective level and in the most effective way.

5. Such cooperative ventures can only be successful if all participants understand their obligations and if effective planning has laid the foundation for the effort.

With the demand for accurate health information from people of various backgrounds and educational levels, and with the enormous proliferation of materials and services in the health area, the skills of librarians are vitally important as a part of the health care team. Just as no one professional--the physician--can deliver all health education, so no one type of library can assume all responsibility for the selection, collection, organization, and dissemination of information in print and nonprint form.

The layman will approach that library which most nearly matches his perception of the natural place to go in order to receive help with his information need. It is in this light that the public views the library and turns to it as the institution which is able to assist when there is need for understanding of a health situation. The library chosen may be the public library, the hospital library, or the library of an educational institution. Hence, whereas health care is the acknowledged and recognized responsibility of the professional health care team, the expertise intrinsic to the collection and dissemination of information is a natural and basic attribute associated with the library and demands the skill of the complementary profession of librarianship.

Confronted with the increasing number of medically oriented questions which laymen are asking, libraries have found themselves posing questions which they are insufficiently prepared to answer: What information is valid? How much information should be supplied? What are the risks of misinterpretation? What are the legal implications? What is the ethical obligation? What other professions, agencies, and institutions are involved in the lay education enterprise and what are their responsibilities and capabilities?

In order to begin to find the answers, it has become imperative for libraries to identify their role in the health endeavor and make that role patent to themselves, to other health professions, and to the layman whose health status within the health spectrum, at any given time, may alter his perception of library focus. To a patient, or to a member of a family acting as surrogate for a patient, the hospital library may be seen as a natural place to turn for clarification of a medical diagnosis. On the other hand, a layman in good health, or with only suspected health problems, may view the public library as the place where he can best increase his understanding and, in the process, become a better guardian of his health. In any case, the profession of librarianship

becomes a natural adjunct to the health care team as an institution to which the layman feels free to turn. The possibilities for effective cooperation are nearly infinite and the obligation to explore and delineate an appropriate role is compelling.

The Purpose of the Institute

The goal of this Institute has been to bring together a broadly representative group of librarians--health sciences and public--to spend a concentrated period of time analyzing, assessing, and planning for the contribution which librarians can make to the health care information needs of the consumers of health care. With that goal in mind, the Institute has been structured to:

1. Acquaint participants with the issues, needs, and opportunities in patient/health education and the library's role in delivering information services.

2. Prepare participants to cooperate with physicians, other allied health personnel, voluntary community associations, and library networks in the support and delivery of health education.

3. Explore the clinical, ethical, and legal dimensions and implications of providing health information to laymen.

4. Introduce participants to lay materials, both print and nonprint, in the health area and the bibliographic paths to these materials.

5. Provide opportunity for the participants to utilize the varied backgrounds, skills, and experiences which they bring to the Institute and to conceive potential cooperative relationships between various kinds of libraries and the primary health care providers.

Personnel of the Institute

Participants in the Institute have been chosen from the library community to represent as wide a range of professional experience, viewpoints, and situations, and as diverse a span of geographical locations, as possible. Representatives from hospital libraries, university medical libraries, public libraries, community college, and state libraries have been selected to take part in the deliberations. The geographic spread is wide--sixteen states are represented from New York to California and from Minnesota to Texas. Both large and

small library systems and urban and non-urban institutions have spokesmen.

The plenary sessions have been planned to provide exposure to as wide a range as possible of interdisciplinary insights relative to patient and lay health information needs and the resource speakers are affiliated with a diversity of health institutions, professions, and agencies. Viewpoints will be presented by persons from the various fields of medicine, nursing, social work, community medicine, law and librarianship as well as by representatives from health agencies, professional associations, and national institutions. General discussions and mutual questioning will give additional perspective to each session.

Organization of the Institute

Plenary Sessions

Six plenary sessions have been planned and will focus on:

1. Patient/Health Education: The State of the Art
2. Patient/Health Education--Issues, Problems, and Opportunities: An Interdisciplinary Symposium
3. Alternative Patterns of Cooperation in a Variety of Settings
4. Library Materials Supporting Patient/Health Education
5. Legal, Ethical, and Social Dimensions of Patient/Health Education
6. Establishing and Maintaining Patient/Health Resource Centers.

Workshop Sessions

Workshop sessions have been designed to facilitate communication among participants, to stimulate discussion of the issues involved, and to evolve potential plans for cooperative action. Discussions will include, but are not limited to, such considerations as:

1. The role of the library in patient/health education in relationship to other professions

2. Organizing for interlibrary, interdisciplinary health education

3. Implementing the patient/health information center.

Participants will work in three assigned groups throughout the week with each group being asked to develop an independent proposal for health education library services in the area of lay health information.

Librarians currently working within the health care complex--hospitals, medical schools, medical institutions--compose workshop groups A and C; librarians identified with the public sector--public libraries, state libraries, community college libraries--compose group B. The fact that there are two groups composed of medical librarians to one made up of public librarians reflects the fact that there were approximately seven times as many health care librarians as there were public librarians who indicated a desire to attend the Institute.

Copies of the proposals drafted by each group will be distributed to all Institute participants on the final day of the conference and discussion will follow. The completed proposals will also be assessed independently by an interdisciplinary panel of resource persons representing various of the health care professions and comments will be brought to the last plenary session for open discussion.

Field Observations

Arrangements have been made for field observations of a variety of institutions and facilities actively involved as resource centers for health information, each in its own way and to its particular lay clientele. Participants will visit the KOM Regional Medical Library, the Shiffman Library of the Wayne State University School of Medicine, the Harper Hospital Medical Library of the Detroit Medical Center, the Health Care Institute--Wayne University's impressive total health care complex--and the Detroit Public Library's TIP Information Center. Each institution represents an outstanding effort to put into practice philosophies and plans which have been thoughtfully and carefully conceived to serve consumers of health care and to respond to the public need.

Evaluation of the Institute

Pre-measurement and post-measurement instruments have been developed to assess both initial perceptions related to various aspects of the librarian's role in the provision of lay health information and changes in those perceptions as a

result of the Institute. Results of the evaluation will be analyzed and reported in detail in the Proceedings.

In conclusion, while every effort has been made to facilitate an interchange of information, insights and practices between many health care professions and institutions, in the final analysis it is only from within the profession of librarianship itself that the role can actually be developed and its performance assured. The participants who are here have wide and varied experience and talents, have demonstrated a dedication and concern for a clearer identification of the librarian's place in the health endeavor, and can add breadth, depth, and perspective to librarianship's recognition of its dynamic role in the total health education endeavor. The thoughtful consideration which should result from this Institute can become a powerful catalyst to assure that such a role becomes an actuality and that the expertise of the librarian effectively augments the total consumer health effort.

PATIENT/HEALTH EDUCATION--THE STATE OF THE ART
A Keynote Address

Harold H. Gardner

In our discussion of patient/health education, two concepts will surface recurrently and require definition.

The first and most important, from my perspective, is the differentiation of health vs. medical care. I'm assuming that the goal of this group of librarians, and in fact the goal of all health care systems in this country, is the health of the population. However, there is no current substantial correlation between the level and type of medical care in the United States and the health of the population. I think you need to dwell on that for a moment. There is, in fact, no defined relationship between the number of hospital beds and their occupancy, the number of doctors and how busy they are, and the general health of the population. Therefore, it is important, as a starting point, that we define issues of health and health care from issues of medical practice and medical care delivery, in spite of the fact that the two areas overlap and that in many settings the terms are used interchangably. Those who control the medical are process, basically physicians and hospitals, would like us to believe that their services are essential to the health of the population. Therefore as a starting point, I want us to begin to focus on the issues of health and the role of the librarian and of health educators in addressing health issues rather than on our participation in the medical care programs and the medical care process.

Secondly, I wish to propose the premise that financing leads to form and that form leads to function. In our efforts to achieve change or social improvement, we tend to first focus on the functional outputs of organizations or individuals, but I submit to you that it is useless to try to change functions unless one changes the organizational form within which function takes place and unless you begin to address how organizations are financed.

Harold H. Gardner, M.D., is Executive Director and Director of Primary Care Programs at Wayne State University Clinics and the Health Care Institute, Detroit, Michigan. He is Professor of Medicine, Community Medicine and Family Medicine, Wayne State University School of Medicine and Adjunct Professor, College of Nursing and School of Social Work.

The late John Knowles, then president of the Rockefeller Foundation, has published a book with contributions from a number of different authors, entitled Doing Better and Feeling Worse. The dichotomy of focus in that book is the dichotomy of health vs. medical care. If we look at what "doing better" means in this country, we are talking about at least a $160 billion dollar health care industry. Of that $160 billions it is estimated ninety percent falls in the arena of medical care. We are talking about an industry that on a per capita basis spends more on medical care than any other country in the world. And, as has been suggested, you simply cannot correlate those dollar expenditures with the health indices of the serviced population. There are some of us who are bold enough to suggest that this medical hospital complex does in fact represent a veritable monopoly. If ninety percent of the health care resources in this country are being controlled by an establishment which is predominantly acting in the proprietary interest of the medical hospital industry and if, in fact, these expenditures do not correlate with the health of the population, then it seems to me that we have a major problem.

As I reflected on my topic, "Patient/Health Education-The State of the Art", I found it undefinable. Essentially, we do not have a genuine and effective patient/health education program in this country. Part of the problem is that only an extremely limited percent of our health care resources are currently being committed to health education programs as opposed to medical care programs. Therefore it is absolutely essential that we address issues of organization and issues of financing, as we talk about health and expanding roles for new health professionals in the delivery of health care. We have to look at the kinds of organizational formats that are being developed which warrant financing, and stable financing for those organizations.

For example, at Wayne State University's Health Care Institute we currently have two types of nurse specialists. One of them is a free standing primary care nursing group who are financed through patient health services fees and by third party reimbursement, who are self organized and who, in fact, function within the constraint of their training and their licensure. The second group works in medical services, for example as a part of family practice or oncology services, where their function and the organizational format within which they function are of a medical model. Invariably, they function as physician extenders rather than as nurses, as their reimbursement basically comes from physician fees. The function they perform is dependent to a very large extent on the organization within which they work and how that organization is financed.

The dilemma of individual freedom vs. societal constraint

is the context within which the future of patient/health education will be determined. Virtually, every major issue that has influenced improvement in this country has been the result of societal constraint. This constraint, and the societal consensus which underlies it, has led to public health legislation dealing with clean water, sanitation, vitamins in bread and a whole host of other factors which are predominantly responsible for the improved health as documented by the health care statistics generated within the country. However, every piece of governmental legislation and regulation brings about constraint on individual freedom.

When we begin to address the predominant problems which jeopardize the health of the American public, we find that at the top are cancer, heart disease, hypertension and strokes, and accidents. The fact of the matter is, the incidence of every one of these, cancer possibly less so than others, is dependent upon personal behavior. The precursor of these health hazards are smoking, alcoholism, obesity and, in terms of accidents, negligence. When one looks for societal constraints on these matters, there are virtually none. When one looks for the influence of the medical profession on the outcome of these diseases, there is virtually none.

The challenge to the art of health education is to achieve behavior modification - reasonable control on the part of the general public over smoking, alcoholism and substance abuse, diet and nutrition, and accidents. It is clear from a number of studies that information dissemination alone is not the answer. For example, I don't know of anyone who smokes who doesn't know that it's bad to smoke, but it doesn't prevent people from smoking. This represents the very real dilemma of health education.

Less than one percent of the budgets of hospitals and health care organizations are programmed to deal with the complex issue of health education. In fact, the medical establishment does not and cannot deal with this side of the equation, because there is no incentive to do so, and because it is extremely proprietary about controlling and consuming the health dollars. On the other hand, are we willing to legislate the kinds of constraint on personal freedoms that would indeed allow us to begin to get some behavior modification in those areas? That's the dilemma we're faced with and it's very real and difficult.

From my perspective this gathering is very important because, in a very real sense, libraries across the country are the gate keepers of information. Information may well prove to be an effective mechanism in dealing with behavior modification. I believe, however, it needs to be structured and organized,

adequately financed, and independent of the proprietary elements that currently encompass our medical care process. The seriousness of society's needs for effective health education is underscored by the cost of treating or curing diseases. Roughly forty percent of the $160 billions expended in the medical care arena each year, are public tax dollars. It would seem, therefore, that some accountability to the tax payer needs to built into the expenditure of those dollars. The Medicaid program in Michigan alone is costing almost $900 millions each year, of which half, or roughly $450 millions are tax dollars. It is not unrelated that, since the mid-sixties, Michigan in its expenditures for higher education has dropped from ranking near the top of the forty-eight states to now near the bottom.

How long are we prepared, as a society, to let individual behaviors be destructive, not only of that individual but of the rest of society? Should there not be some level of public accountability if the behavior of individuals is, in fact, impacting on health including the fiscal health of society? Among the chronic illnesses which cause people to require long term and custodial care, strokes account for a very large percentage and are directly related to hypertension. On down the list a little is cirrhosis which is directly related to alcohol abuse and nutrition problems. It seems to me that if people are able to drink, be overweight, and engage in other high risk behaviors that predispose them to becoming ill and public liabilities, there ought to be some prerogative for society to impose constraints, unless effective programs of health education can persuade them to modify their behavior voluntarily.

There has been an assumption on the part of the medical care system that it is dealing with health maintenance. Indeed, because of the dollars involved, the system is now attempting to extend its influence into the emerging social health care arena. A concept developed in the 1960s proposed that the academic medical center be the hub of the health care delivery system whose influence is the health and social health care arenas including factors that deal with housing, nutrition, and other social issues that relate with health care. The intent of the proposal was to extend the influence and the incentive of the medical center through all of these areas. And, in fact, that extension of influence begins to happen when virtually all programs reimbursable by third parties require the sanction (or order) of the physician.

If people are functioning as physician extenders in new roles, whether they be psychologists, social workers, or nurses, they generally are reimbursed for their services under the name of the physician, which leads to control of the entire medical-

health arena by medicine. Already, we are discovering that such an arrangement is problemental because the cost is prohibitive and, further, it fails to address health issues. The medical establishment is not programmed in the health maintenance business; rather they are in the business of caring for people once they become un-healthy.

I am suggesting that we divide medical care from health maintenance. I propose that each arena be separately financed. Although I believe that they should be coordinated, we must not assume that those who are trained and equipped to deal with tertiary and highly sophisticated kinds of medical problems are able to deal with primary health kinds of problems. The fact of the matter is that as we begin to look at primary health care it does, and it should, focus on issues that promote health, issues that attempt to modify destructive behavioral patterns.

Wayne State University has submitted to the Medicaid program in Michigan a proposal for delivering and financing primary health care separate from specialty and hospital medical care. The cost per capita for Michigan Medicaid is now approaching $1000 per year. Good health care should be able to be provided for less than that. The reason for our high cost is that the hospital utilization by Michigan Medicaid recipients runs as high as 2,000 hospital days per thousand people per year in some areas. Nationally it is about 1,000 and in downtown Detroit about 1,700. Again there is no correlation between the health of those people that occupy beds at that rate and those people that occupy beds at a lower rate, which means that we have to look toward a system whereby professionals are not driven by the incentive of the medical care process and are able to be recognized for the appropriate health services they perform. Within our primary care proposal, the professionals involved - nurses, social workers, psychologists, nutritionists, and physicians' assistants - are treated as autonomous practitioners. Each of them is reimbursed for services independently of each other. We have also included health education in that reimbursable package and we have not yet clearly defined who will be participating in health education. I think that is a very legitimate role for librarians. I believe strongly that recognition of and reimbursement for services delivered, independent of the presence or participation of the physician, is absolutely essential if we are going to 1) prevent monopoly on the part of the medical establishment and 2) encourage the kind of involvement health educators should have.

If a plan such as I propose were to be implemented, could health educators then begin to deal with people and their problems in a way that brings about change? Interestingly enough, under the traditional structure, consumers have been

very demanding of high technology services. If you do not use the most sophisticated diagnostic test, regardless of its effectiveness, poor people especially feel that they are receiving second rate care, whereas the fact of the matter is that some technology is of very questionable value in medical care management. Under a new system of primary care, how could one begin to deal with the consumer or patient in such a way that information does more than create anxiety and create symptoms that predispose to treatment?

One other distinction I would like to explore with you is the difference between illness and disease. Disease represents an identifiable pathological condition that generally is definable in medical terms and often has a prescribed treatment if not a cure. The thrust of medical training is to diagnosis disease and treat it within the context that there is a cause and a cure for every disease. On the other hand, illness may well generate symptoms and dysfunctions similiar to disease, but does not represent an entity for which there is a cure. Up to eighty percent of the patients seeking help from medical practitioners have no definable disease. They do have headaches, which may not be because of hypertension, for example, but rather of stress. Particularly in this complex society there is an increase in people who are disabled because of illness which is not disease. However, they enter a system which is disease and cure oriented. The problem is that we deal with a tremendous volume of patients who are symptomatic of illness. If we cannot prevent ill people from getting tertiary care we face not only a major cost problem but also a functional problem. Ill people who seek tertiary care facilities inevitably leave dissatisfied because their problems have not been met.

By the same token there are a whole host of people who do have disease. In many ways I think that the primary approach to health education should focus on those who are ill and without disease, by protecting them from getting into settings that may be hazardous to them; and secondly, on those who have disease, but who need supporting kinds of assistance while in treatment. I currently see a number of patients, particularly elderly patients, who obstensibly get into my office because they have mild high blood pressure. Most physicians focus on and treat that condition. But their reason for being there really is not blood pressure, it is their need for social well being and, unless I can address that, I'm simply aggravating the process that is not in place.

I suggest to you librarians a challenge, that as your profession moves into a more active role in health education and primary health care, you seek financing for services delivered in a direct way, rather than in an accessory way. Secondly, I urge you to focus in a major way on how to

prevent people from moving into unnecessary tertiary care. There has been a great deal said in this country about lack of access to needed medical care services. It is mainly nonsense. We have more medical care to sell in this country, in most places, than we know what to do with. We need to begin to foster programs that, in fact, protect the consumer against unnecessary medical care. It seems to me that in many ways the library profession might be addressing the same issue as pharmacy. Pharmacy for a long time has been a dispensing profession. Pharmacists are now beginning to move into patient care. From my perspective, the predominant function they need to play is to protect people from using drugs they do not need, a consumer advocacy/ patient advocacy role. Librarians, too, although you will continue to dispense material and information, will also need to play a role as consumer advocate, in protecting people from getting into medical channels that well may be hazardous to their health.

I further believe that librarians must begin to look at consumer health education, from a non-medical perspective, with concern for behavior modification. I have been fascinated with the evolving use of video as a tool that may well effect behavior modification. I think that there are a number of other modalities that may be useful to people, not only in defining problems but in helping them to deal with the problems, Lastly, I clearly believe that over the next decade there will continue to be tremendous pressure within this country for legislation which will regulate many of the issues we talk of. I have mixed feelings about that. On one hand I am a strong advocate of individual freedoms and, on the other hand, I believe that we have to be able to bring some sort of societal constraint on individuals whose behavior is a detriment, not only to themselves but to the rest of society. I believe we will see increasing legislation that will in a very real sense begin to pave the way for control of these kinds of issues. The alternative is an effective health education system.

PATIENT/HEALTH EDUCATION - THE HOSPITAL LIBRARIAN'S ROLE

Barbara Coe Johnson

Bearing in mind that the primary purpose of any hospital is to provide the best patient care possible and that the library of a hospital exists to support the hospital's goals, I think the fact that the hospital library has a role in patient education should be obvious. Quite the opposite, however, seems to be true. In their analysis of the 1975 American Hospital Association (AHA) survey of hospital inpatient education, Lee and Garvey[1] indicate that among the 82 hospitals* which participated in follow-up meetings, librarian involvement in patient education was not mentioned in hospitals having fewer than 400 beds.

As usual, the answer to the question of why this should be true is complex. It is not within the scope of my remarks to treat the subject exhaustively, but I shall attempt to outline a few contributing factors. Perhaps the paramount one is attitudinal and based on the historical development of hospital libraries. Hospital organizations, library organizations, medical organizations, regulatory agencies, hospital staff and hospital librarians alike generally perceive the function of the library to be that of providing information which will allow those involved in direct patient care to be good practitioners.

A patient library function, if it exists at all, is seen as "icing", as providing recreational material for those recuperating, and is often an extension service of the local public library. With some exceptions, notably in Veterans Administration and Kaiser-Permanente hospitals, few hospital librarians feel that the library has a major role in direct patient care. This attitude is understandable in view of the historical

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*The survey universe was made up of 2,680 community, nonfederal, short-term hospitals.

development of the hospital library as the physician's tool. Only lately, for example, has the Joint Commission on Accreditation of Hospitals (JCAH) gone so far as to add "and hospital" to the always present "medical staff" when describing the population to be served by the Professional Library Services; certainly JCAH omits patient education functions when establishing standards for hospital libraries.[2] The AHA does not mention the hospital library in either its Patient's Bill of Rights[3] or its statement of the Role and Responsibilities of Hospital and Other Health-Care Institutions in Personal and Community Health Education.[4] The National Library of Medicine (NLM), when interpreting and administrating the Medical Library Assistance Act of 1965, sees its role as supporting library service to the professional worker and has consistently denied responsibility in the area of library support for patient education. In fairness I should say here that NLM cites other federal agencies that should carry this burden. One cannot, indeed, deny the existence of such federal agencies (notably the Bureau of Health Education, the Office of Health Information and Health Promotion and the National Center for Health Education) which have mandates in the area of patient education, but none of them has the element of bibliographic control so necessary for libraries. The Medical Library Association and Special Libraries Association, while now making tentative steps toward recognizing the possibility that patient information provision may be in the purview of the hospital library, still primarily concern themselves with activities having to do with information designed to fill the needs of health professional library users. With such a heavy weight of traditional interpretation as to the hospital library's role in patient education, it is little wonder that hospital librarians, by and large, match their attitudes to those of the mainstream.

Another barrier to hospital librarians' acceptance of responsibility in this area is that they are not trained to give direct patient care. They feel, with undoubted justification, that they would be overstepping ethical boundaries in the area of patient-professional relationships were they to assume such a role. They realize, too, that technical information can be not only misunderstood but even anxiety-producing when presented to the layman patient without having perspective established by a health care professional. Many, moreover, feel that filling information needs for the general public, including health information needs, lies in the domain of the public library. Hospital librarians also are uncertain about their competency to choose authoritative print or other media materials designed to meet the needs of laymen; their expertise lies mainly in making technical information available to the professional practitioner whose own trained judgment will evaluate the worth, or lack of it, of the information presented.

Certainly a practical problem is how to support the library

costs of patient education. The AHA survey cited before reveals that 58.7 percent of the hospitals surveyed finance patient education programs through daily room charges; 7.5 percent bill separately; 15.5 percent use gifts or grants; only 2.6 percent budget separately. In general, the cost of patient education is viewed as being an integral part of the activities of departments which already have budgets. Some few states have enacted legislation allowing patient education costs to be reimbursed by third-party payers and/or Medicaid, but most insurance reimbursers follow Medicare guidelines and do not allow reimbursement except for specific educational functions designed for a particular patient, like physical therapy instructions for amputees.

The last barrier I shall mention is also highly practical. Hospital librarians are so busy with what they and their patrons perceive as their primary activity that few have much time to be concerned with what is seen as, at best, a secondary function.

Times, however, are changing. Nowhere do these changes have greater impact than on hospitals and other health care delivery institutions. And, whether we realize it or not, as the emphasis shifts in hospital goals so will the emphasis have to shift in the hospital library which exists to support these goals. Patients (health care consumers) are coming to understand that knowledge about illness and medical care is not the exclusive property of health professionals.[5] As they realize their right to know, they are becoming more vocal in asserting this right. As evidenced by the growing number of malpractice suits alleging failure to disclose sufficient information to patients, they are seeking recompense when they feel their rights have been abused.[6] Recent court decisions have supported the requirement that a patient give "informed consent" before submitting himself to hospital procedures.[7] Let us call this the litigious spirit of consumerism. And hospitals are prime targets, so they must respond.

Other key elements in promoting the importance of patient education are: realization that knowledge, if acted on, can change and improve one's health, especially in terms of compliance with prescribed treatment regimens;[8] evidence that the cost of health care (especially in the area of admission and readmission to inpatient facilities) will decrease when programs of planned patient education exist;[9] and availability of communications technology which makes planned patient education feasible.[10]

Some common factors of patient education programs appear:

1. A team of health care professionals, usually composed of some combination of physicians, nurses, pharmacists, dieticians, social workers, and health care educators,

is responsible for designing and implementing patient education programs,[11] although the makeup of the team may vary.

2. The institutions involved have made management, staff and financial commitments, direct or indirect, to support patient education programs.

3. Successful programs, causing desired patient behavioral changes, include both intra- and extra- hospital components, e.g., the patient has a tailor-made discharge plan to follow when he leaves the hospital.

4. Successful programs usually include the patient's family.

5. Warm, non-condescending attitudes on the part of the health-care professional who actually instructs the patient are extremely important, regardless of whether or not the patient education program is informal or structured.

Now, with the issues and problems presented to the hospital librarian by the health information needs of the layman patient at least sketchily outlined, let me proceed to discussion of how the hospital librarian can rise to these challenges. Several recent papers have isolated or synthesized various views on the hospital librarian's role in patient education, either directly or by inference.[12-19]

The most obvious role the librarian can play is to gather information relevant to the individual patient's illness and disseminate it to the planners and purveyors of the patient education program. The librarian, in doing this, is uniquely able to include both technical and non-technical material in both print and non-print form. Another role often mentioned is for the hospital librarian to store, classify and organize patient education materials, preferably in a library designed for the patient and his family.

I must say that while I can wholly agree with the first of these, I find the second somewhat less acceptable, however much it may superficially appear to be desirable. I agree that organizing and classifying patient education materials is something librarians can and should do, but I would be concerned if the library were to store individual packets designed for an individual patient, each of whom has his own unique disease pattern. I would prefer to see the library hold a comprehensive collection of materials written or produced for the lay public, by recognized authorities. These the patient or his family could use without let or hindrance. But I don't think a patient would profit much were he to have

to choose from a collection of individualized materials which might or might not meet his needs. It seems to me that the patient for whom a particular set of materials is assembled should be the one who receives it. Further, its delivery should be mediated by a health professional who knows the individual and can use the library materials as reinforcement in teaching. Ruth Jones, Chief Librarian of the VA Hospital in Spokane, Washington described just such a system and its success.[20] When a patient or a member of his family asks the library for information about his illness, she copies relevant pages from books already accepted as authoritative by the Patient Education Committee (PEC) and also, perhaps, includes a simply written article or two from nursing journals. She informs the head nurse on the patient's unit of what information she has given him. She then conducts a more conprehensive search, refers the material so gathered to the PEC, which in consultation with the patient's physician, decides what is most suited to the person's needs. This supplementary material is again referred to a health professional for mediation, and passed on to the patient.

At Harper Hospital, we intend to try this method to supplement our present program. Our patients' Booktrain service to the floors is largely designed to meet recreational needs. We have a patients' library, with recreational components and a comprehensive and current collection of authoritative lay medical material to which the patient and his family have access, but we have not heretofore attempted immediate individualized service at the time the request is presented nor have we included a follow-up.

Instead, we have felt that professional intervention was necessary before information directly pertaining to the patient's particular disease was made available by the library. Simply speaking, we have not denied the patient his right to information, but we have insisted that someone who knows him be aware and possibly choose material for him to read or view. We have asked the patient to get a "prescription" to use the professional collection from his physician, nurse, or social worker. If the patient experiences difficulty getting a "prescription", we call Social Service and ask a worker to intervene on his behalf and find out why communication has broken down. Our Social Service Department welcomes this approach. This has worked reasonably well, but I now see that such delay is not really necessary, providing a mechanism to support a simpler approach can be established.

A good deal of groundwork communication information exchange and administrative action will have to take place between the library and those directly in charge of patient education before the library's ability to perform this kind of supportive service is recognized and can routinely become available to

patients. I see little to stand in the way of achieving this goal, however, especially if the library takes the initiative in demonstrating its ability to perform such a service in a reliable manner.

To me the crux of the library's role in patient education lies in this last statement. Patient educators are accustomed to having the library supply information they need to help the patient but they are not used to the idea that the library may be able to provide material for the patient to use to help himself. Librarians must investigate the organization and instrumentation of patient education in their own institutions and then initiate the activities which will best allow the library's resources to be exploited to the patient's advantage.

Another place where hospital librarians initiative would be useful would be to add their voices to those of others[21] addressing federal and library organizations and demanding the kind of bibliographic and quality control of lay-oriented medical print and non-print materials which now exists in refined forms for information designed for the health professional

More cross-fertilization needs to occur among librarians in health institutions and those working in public libraries, too. Each has a role in consumer health education, one in the atmosphere of the hospital where the consumer is part of a virtually captive audience, and the other in delivering reliable health information to the non-institutionalized general public.

Librarians in both kinds of institutions have similiar problems but they have different kinds of expertise. What is needed is recognition that their differences can be made to complement each other, and that similar kinds of collections reinforce the worth of each other rather than simply constituting wasteful duplication.

I have tried in this paper to describe the present status of patient education in hospitals and delineate areas in which librarian initiative can improve the quality of health care information available to the lay person, whether he is a patient in the hospital or a member of the community.

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PATIENT/HEALTH EDUCATION-
A PHYSICIAN'S VIEWPOINT

Fred W. Whitehouse

In commenting on remarks of previous speakers it would appear that most of us are recognizing that the activities of medicine are more likely to be out-patient rather than in-patient. By that, I mean that more individual patients with problems will be seen in the doctor's offices and in the clinics than in the hospitals, primarily because of the cost of medical care, but also because there is a great interest on the part of the human beings in staying out of the hospital unless they are desperately ill. Also, many things can be handled better under home circumstances than in the hospital.

This should fully warn public librarians, in contrast to medical librarians, that the time is coming when they are going to have to be involved. At the present time, most people can go out and buy many different items at the book-store; they can obtain what they want on heart disease, cancer, diabetes, low cholesterol or the danger of salt in the diet. There is an easy access to information on the part of any individual who is interested, without even bothering with either physicians or librarians. Sometimes both physicians and librarians may end up acting as "do-it-yourself undoers" in an attempt to try to put the pieces together after the public has either gotten misinformation or misinterpretation of information.

It is my personal belief that it is a good idea for people who are interested in information and its dissemination, as librarians are, to become involved in this area. I am personally active in the American Diabetes Association, a voluntary health agency aimed at both the professional, working with diabetes, and the individual. To my knowledge, we have physicians, podiatrists, dentists, nurses, social workers, dietitians, psychiatrists, psychologists, but not one librarian.

While I am speaking today with the perspective of a physician,

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I am speaking as an individual and not for physicians elsewhere. Someone else might take an exact opposite view and might stand up and say, "I don't think patients should know anything". My viewpoint has been based upon about twenty-five years of experience handling patients in internal medicine, my speciality, and particularly in diabetes. I doubt that there is any other particular malady that affects human beings in which patient education had been available as early as in diabetes. The reason for this is that a patient with diabetes sees a physician about once every three months, but has to cope with his own illness everyday. In a sense, he has to be his own medical counselor much of the time. This has been recognized since insulin was first discovered in 1922 and diabetes was no longer an illness that cost a person's life within six months. These activities are the background of my remarks.

There are two groups of people whom you will need to consider. One group consists of non-patients, you and I, an important group to consider here because, if the old adage, "an ounce of prevention is worth a pound of cure" is true, the whole idea of health information is to keep people healthy. People are interested in all aspects of life which concern health information. Is junk food good or bad? What about cigarette smoking? How do you know you have high blood pressure? Why should you use seat belts in the car? Why not use seat belts? What about fatness? You could list any number of things that relate to health maintenance.

The second large group consists of patients whose health information needs relate more specifically to their particular problems, such as diabetes, emphysema, heart disease, cancer. Obviously this information is going to be more specifically and precisely oriented to people with chronic illnesses. One does not see much information on tonsillitis or on the common cold, because they are self limiting or easily curable. There is no demand for information on appendicitis but there may be demand for information on chronic headache or things of that nature.

The point of the information for the second group, the patient, relates to coping; how to do this or that, to survive and then to prevail. By survival, I mean to prevent yourself from dying as a result of whatever you've got. In diabetes, for instance, it is important to have certain single concept ideas in patient learning initially. The diabetic has to learn about a diet, about how to give a shot of insulin, perhaps how to check himself by urine tests, how to cope with insulin reactions. These are things a patient needs to do to survive.

As a previous speaker has said, you can't dump all the information at one time. To begin with, most of the time the

patient is in a state of emotional shock immediately after learning the diagnosis. Later the need is to know things that will make that patient prevail. By prevailing, I mean to have a fullness of life and to get back into a lifestyle that is desirable. A young man was in the office this morning whose father asked whether his son, who is a diabetic, could take part in athletics? The answer is, of course, that he can participate. But these things need to be known. Once one has survival information for a given patient, then the need is for prevailing information; how to travel with the disease, how to go to school with it, what problems may exist with athletics, all the things that diabetics, or any other person, may need to know. Where are people going to go for answers? They can ask their doctors, but maybe they can find information like this in the library.

These are the kinds and levels of information you will need to offer your clients, I think; information to the well who need to know why and how to stay that way, and information to those with chronic disease, who need to learn how to survive and prevail.

When preparing information you will need to consider several items. It is one thing to want to give information, it is another to prepare for giving it. What information are you going to want to give to a person? What information that exists is science? What information is hearsay or opinion? What is traditional information which is often based on good observations but may not be proven or disproven? How are you going to present this information? Are you going to have it as a written word, pamphlet, booklets? Should the individual get involved in tests to see if he has learned what you hope he will learn? If there are audio visual resources, are you going to use tapes, slides, movies, television, records, tapes without visuals? What type of information are you going to have, and are you prepared in your libraries to provide the various methods of information? Everyone of these various methods of information-giving has been tried in our diabetes association, including learning machines.

Who is going to prepare the information and how will you balance the areas of medical dispute, honest dispute, among physicians and scientists? Who is going to say whether avoiding eggs and animal fat really cuts down the hardening of the arteries, and how are you going to present a balance of viewpoints? How are you going to present a balance of viewpoints as to whether, if you eat bacon, you might get cancer? But what are the chances of getting cancer? This whole issue of risk versus benefit is being fought out right now with saccharine and nitrosamines.

Again, medical information, or patient information, can

become obsolete. Tomorrow something new outdates what you have today. How are you going to update? Who is going to update? How are you going to know, as librarians, what is obsolete? Who is going to tell you, and how are you going to find out? For what level of literacy are you going to prepare your health information? How are you going to reach all the people who need to know? In diabetes, we see the illiterate and the scholarly. Both need and deserve information, yet the requirements are different. How are you going to be all things to all people?

Also, consider individualism as it relates to health information, such factors as ethnic varieties and language varieties. For instance, in our city we have Spanish and Arabic languages and a properly oriented program of information can be very helpful. Age is a factor. You may well have information aimed at the young which is inappropriate on the same topic for the old or vice versa. From experience with the diabetic program at Henry Ford Hospital it is apparent that one must be prepared for great variety. You need to recognize this variety of clients in order to serve them adequately. Even though you may have a library in a well-to-do area, you have some people in that area who don't read well.

It is necessary to discern between presenting facts and offering perspectives; and the opportunity for applied wisdom and motivation enters here. All of you know about cigarette smoking but millions smoke. Yet, for an individual, maybe it is possible that the cigarette smoking is the lesser of evils at any given time, so one cannot always judge the results of the information which is being given out. Health information may need to provide motivation. The appropriate application of knowledge is wisdom. What you are aiming for is really that the informed layman should be wise regarding health, not just factually supplied. Just because people know a lot of facts does not mean that they are informed.

This brings up a third area of thought. Not everyone is demanding health information, not everyone reads books, or wants information or cares. Should you, as a librarian, take an aggressive role toward health information by supporting intrusion into their lives through the support of school curriculum, home television exposure (other than General Hospital or Marcus Welby), educational materials in libraries supplied by voluntary health agencies? We have been trying to do this in Michigan through our American Diabetes Association, Michigan affiliate. We offered to put pamphlets and government publications in libraries.

It has been said, and I think I picked this up in preliminary remarks in this session, that if health information is a

right, then following the directions of the information becomes a responsibility, a personal responsibility of the person. If one has rights, one also has responsibilities. What is the role of the librarian in this issue? Many times we know as physicians, as health care providers, that it is important for people, or it seems to us important for people, to understand certain things, yet it is very hard for us to get them to even come to the area where we can help them to understand. In diabetes it is clear that if the behavior is modified, knowing facts is not enough. Common sense helps, but what the person does with the facts is what is crucial. You try to motivate people in different ways but motivation is difficult. Possibly it might even be applied best by motivating through co-insurance factors.

How do you prevent costly duplication of efforts? We have struggled in diabetes circles with this issue and have come out, through the National Diabetes Commission, with a National Clearinghouse of Information on Diabetes which is run by the National Institutes of Health. Yet you have to remember, also, that just because two different people in two different areas write two different pamphlets, it does not mean that only one is good. It may indicate two different attitudes. Nevertheless, having the knowledge that information is available, and finding that information, often saves precious time and effort. There may be someone in North Carolina who wants to learn what someone in Michigan has written and hence may not have to write it over.

The Diabetes Clearinghouse is now struggling with the problem of evaluative comment on what is available. You are not going to be able to get away with just having the book there listed under the Dewey Decimal System; you are going to have to say that this book is good; that this is what the book says. It is not enough just to say you recommend an item, you have to say that this item on emphysema is simplified, or it gives you facts, or that it is very detailed. In health information areas the librarian should be prepared to offer brief critiques of the work for those who need to know about the piece of education material. And this raises the question of who is going to do the critiques?

Funding considerations were raised earlier and need some comment. Even now patient education as an active Out-Patient Department is, by and large, not generally funded by third party carriers. In the In-Patient Department funding is buried in the cost reimbursement. Many times funding for the patient education has to be done through the individual's own pocketbook.

In conclusion, I believe librarians belong in the health information/patient education team. I am glad to welcome them aboard.

HEALTH EDUCATION - A CONSUMER IMPERATIVE

Peggy A. Turner

My professional education and working experience have been in nursing. For several years I worked in a hospital setting as a staff nurse and more recently, and by far the greater portion of my work experience, I have been a public health nurse. This diversity has afforded me an opportunity to experience and practice in two very different aspects of health care. In the first, the patient was often acted upon, subject to the rules and regulations and requirements of the institution and the wishes of the health care personnel. In the second setting the patient is interacted with, in relationship to his physical and social environment. Also in the latter setting, health must then be looked at in very broad terms for the patient is on his own turf, influenced by and influencing many other systems in his environment.

Health, education, and consumer are words we each use easily and often feel comfortable doing so. Yet each may mean different things to different people so I will attempt to define these and a few others as we work together to fulfill the charge before us today.

Very briefly, health, as defined by the World Health Organization, is a state of physical, mental and social well being. Today we will investigate how each of us can or should contribute to this goal of well being in the area of health education whether we be librarian or nurse, social worker or physician. We will further look at issues, needs, and demands as they relate to health education. As we analyze this definition given, it is apparent that the World Health Organization did not limit its concerns to only the illnesses of the world but did include any and all things that impact on our well being because health is not just the absence of disease. Let us further establish that there are levels of well being. I'm sure that each of us is more intact physically, mentally, and socially at certain times in our lives than at others. This tells us, then, that we are in fact dealing with varying levels of health on a health-illness continuum, and the many points in between these two extremes.

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If we accept the definition of health and the concept that health is not just the absence of disease but includes a state of wellness, then we soon realize that each of us is included within these parameters. In order to broaden our perspective and include all of us, may I suggest at this time that the term consumer of health care be substituted for the term patient. A consumer, a term borrowed from the field of economics, is one who uses goods and services to satisfy needs. Patient implies illness, yet our focus need not nor should be limited to this. We are all consumers of health care, some to a greater degree than others. With this broadened focus, we will be able to look at the health education needs of the total population rather than the limited number suggested by the term patient.

Education is a process of training and the development of knowledge and skill. This occurs in many ways including formal schooling, teaching and training. To paraphrase Sandra Willett, Executive Director of the National Consumers League, consumer education is a process which arms an individual with the knowledge and self confidence needed to choose to spend and/or conserve available resources for the purpose of meeting health care needs. As a tool, consumer education allows for effective use of personal resources through informed rational decision making by the individual. Education, as it relates to health care, provides the consumer with the knowledge base which allows for and encourages responsible health care behavior through a process of informed rational decision making.

Health education must now be viewed along a continuum in order to meet the needs of the total community. Just as every individual appears at a different point along the health-illness continuum, so too must health education be developed and delivered in a manner appropriate to meet those needs at any given point.

Leavell and Clark[1] have given us a model using the concepts of health-illness and it's application in preventive medicine. We can adopt that model and apply it's principles to health education.

STATE OF WELL BEING	Health	Illness
CHARACTERISTICS OF HEALTH CARE	1. Health Promotion	1. Early diagnosis and prompt treatment
	2. Specific protection	2. Disease limitation
		3. Rehabilitation

TARGET AND METHOD		
	1. Groups and communities by organized mass action	Individuals and families
		Individual patient contact
	2. Individuals and family--self initiated or by health care provider by individual patient contact	

The type of health care information required will be dictated by that individual's position in the health-illness continuum. For example, my physician spent a considerable amount of time explaining and teaching me breast self examination when I approached thirty years of age. I had no disease process or symptoms which might suggest a need. This was purely preventive health education and initiated by the physician.

Once the individual reaches the clinical horizon however, the focus for the health care provider and the individual becomes one of disease limitation. I would suspect that a number of inquiries which reach librarians are related to interpretations and implications of specific diagnosis or the type and appropriateness of treatment for specific diagnosis. I would hazard a guess that many inquiries are related to symptoms only, for many people seek information prior to seeking medical diagnosis and care. Many others seek confirmation and validation of information already received, one method of obtaining a second opinion. We see this behavior also in people who "doctor shop". Doctor shopping is different from seeking a second opinion, which is certainly a valid procedure. The person who "doctor shops" seeks three, four or more opinions when he/she is not satisfied with information received from the first, second and third.

Health education, in order to be effective, must also be appropriate to the individual learning needs of each consumer. Factors which influence the assimilation of this information include:

1. The point at which the individual appears on the age continuum. A few years ago, my daughter supplied me with an example of the efforts being made to meet the needs of the young consumer. At age six she came home from school with a coloring book supplied by the A.C.S. She enthusiastically set about coloring the pages as instructed. She then began to ask questions about the lungs and other pictures in the book. As I looked at it more closely, I realized that this simple tool was teaching her about the

effects of cigarette smoking on the body and, consequently, good health practices. I have evidence that this was a lesson well learned as she reminds me and other family members that smoking is harmful.

2. The need for information presented at the level of the individual's level of intellectual understanding.

   Recentl a non-nurse employee of the agency called the office. She expressed much fear and anxiety related to a health problem which she was presently experiencing. In further discussion with her I found that she was very confused by what had been told to her by her physician. She did not understand the medical terminology used and assumed that death was imminent. She and her family suffered much needless anxiety at a time when they least could afford to expend the emotional energy.

3. The elimination of language barriers between care providers and consumers of health care in order to facilitate learning.

   Recently, a staff nurse identified a problem in communicating with a Greek family who had been referred to our agency for service. The nurse felt frustrated at not making herself understood and the family was unable to understand or raise questions which would facilitate their learning. Fortunately, an interpreter was found which has allowed communication to take place. It is slower, it is still frustrating, but at least it is happening.

Let us now put our present health care delivery system and health education into historical perspective. Professional health care has been a privilege available to those who could afford it. As far back as ancient Greece where Hippocrates fathered the development of the role of the professional physician, a dual health care system existed, one for those who could pay the going rate of the day and one for those who couldn't. The physicians were held in high esteem and treated as an elite body. As we can see, not too much has changed in the past twenty-two hundred years. One of the major differences between the health care system of ancient Greece and our present day system was a well developed and legally sanctioned second system parallel to the professional system. This second system, one of self-care/self help, was one in which a sick or injured person who could not pay for professional care could seek advice from fellow citizens. It was later required, by law, that anyone with the skill and knowledge must lend assistance or advice, if solicited, to the ill and infirm. Early in the history of the United States self help/

self care was an integral part of the health care delivery system.

The status of our present health care delivery system must be examined to understand the problems that we face today and how they impact on consumer health education. There is increasing unrest and discontent among the consumers of health care for it is apparent that the systems which affect the nation's state of wellness and are responsible for the protection of that wellness, are failing to meet the nation's health care needs. One need only compare the health statistics of this country with those of other industrialized nations and one puts into perspective the need for priority to be given to health in this country. For example, the infant death rate in the United States ranks us seventeenth in the world.

At the present time, our value system is moving toward the concept that adequate health care, which includes health education, be delivered in a predictable, non-demeaning manner and is the right of all rather than a privilege for the few.

These rights are identified by the American Hospital Association in a "Patient's Bill of Rights." Two of these rights out of the twelve have direct bearing on consumer health education and the process of informed national decision making. The first indicates that the patient has the right to obtain, from his physician, complete current information concerning his diagnosis, treatment and prognosis in language which the patient can be reasonably expected to understand. It also suggests that this information should be made available to an appropriate person in behalf of the patient when necessary.

The second presumes that the patient has the right to receive, from his physician, information necessary to give informed consent prior to the start of any procedure and/or treatment. A recent article written by a surgeon in a Detroit newspaper urged that patients facing surgery be informed decision makers and know the alternative methods of treatment by asking questions. He emphatically stated that the individual must have the final say about how his body will be treated.

These concepts of self determination are implied in the definition of informed consent and have raised many legal and moral issues. Recently a nurse had her license suspended for informing a patient of alternative methods of cancer treatment. The physician had prescribed chemotherapy and the patient was fearful and requested information from the nurse. The patient refused the prescribed treatment and after an inquiry, the nurse was suspended for interfering in the physician-patient relationship. It would appear that the elitest attitudes toward physicians are still with us.

This situation poses a dilemma for the provider of health care information when that person is other than the physician. Consumers of health care are clearly in need of information relevant to their care, as our health statistics indicate. The American Hospital Association identifies the physician as the information giver in its statements relating to information and this attitude was supported in the previous example given. The consumers themselves seek out information from many sources which will help them in making decisions related to their health care needs. More and more consumers are demanding as their right the opportunity to determine what will or will not be done to their bodies and the information upon which to base that decision. Non-physician health care providers are taking risks when we provide health care information to patients and answer questions regarding choices and alternatives in treatment. I suppose we must ask ourselves if the risk is worth taking. I would suggest that we are taking a far greater risk when health care information which could influence the decisions made by an individual related to his care and treatment is withheld. As professionals engaged in human services, we must value the human person above all. We must value the right to self-determination based on informed decision making for to deny this right to others means that it can be denied to each of us.

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THE LAYMAN'S NEED FOR AND ACCESS TO HEALTH INFORMATION: A SOCIAL WORK PERSPECTIVE

Betty L. Rusnack

I have been a social worker and a teacher for many years but not always in the University. When I was engaged in social work service to individuals, families, and groups in a vocational rehabilitation agency, I felt quite comfortable about my practice skills. I considered myself a good field instructor of the five or six graduate students from Wayne State University and the University of Michigan who were in my unit. Issues did not seem as complex before I was in the University as after I entered over ten years ago. My assignment in the WSU School of Social Work has brought me in touch with faculty members and students in all the health related schools and colleges. This workshop provides an opportunity to work with librarians for the first time.

We have been asked to deal in this paper with the layman's need for and access to health information. My University exposure tells me that all those words need to be defined, i.e., need, access, health, information. The Program Narrative describes the workshop as "Patient/Health Education--The Librarian's Role". I would like to comment first of all about education. I have been doing and thinking about patient and consumer education over the past several years. In fact, I have been doing more thinking than doing. I have been teaching graduate students. In many respects, these students are consumers of health care. These are some things that I have learned from my students about education:

1. Education is more than the transmission of information
2. Education is involved in behavioral change
3. Behavioral change involves the whole person: his thinking, his doing, his feeling
4. Change may or may not be desired: it may cause pain

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as well as joy

5. A supporting environment, teacher, peer group is necessary to provide psychological safety for change to take place

6. People are interdependent on each other

7. Change in one part of the system has repercussions and affects another part of the system

When I think about patient/health education, my experience elicits more questions than it elucidates answers. In patient/health education we are dealing with the learner in a situation which is fraught with values and traditions related to the physician-patient relationship to which we all have been socialized over many years. It would seem that an objective of this workshop might be to get a new view of the person as the producer of his own health care.[1] With this view, it might help us to determine what he needs to know and how he will access information. Some things come to my mind which need to be explored.

1. A person may have health beliefs and attitudes that may be contradictory or congruent with the health professional with whom he is in contact

2. Because a client/patient and a health professional come together does not necessarily mean that they communicate with each other

3. In the area of health and health care, people are influenced by friends, TV, newspapers, and many other sources of information which may or may not be more cogent than information provided by physicians or other health professionals

4. Information about the body and disease processes may not be the most essential information needed by the person. Information which helps the person to access the system, to utilize the system, or to change the system might be as essential or even more necessary e.g., what transportation is available to take me to my doctor's office or clinic; what are my rights and responsibilities in a hospital or nursing home; what are copayments and deductibles; what is my congressman's position on National Health Insurance?

5. Health care in this country is big business and represents almost 9% of the Gross National Product. The use of health dollars is influenced by social, professional, and personal values in ways that most of us do

> not fully realize. Consumers are sitting on many committees and boards. The nature and extent of the knowledge needed to adequately carry out committee functions is often overwhelming.

I believe that for too long a time both professionals and lay people have been willing to allow a white curtain to come between health care professionals and patient/consumers. This workshop attests to the fact that this curtain is rising. We need not only to identify the vestiges which remain but to determine what outcomes we hope to achieve. If a goal of health care is to achieve outcomes in which individuals are capable of making informed and self-directed decisions about their health, health care, and the health care systems they use, then access to information which meets the objectives of people is necessary.[2] Further, the layman needs sources of information which he can utilize intelligently. The purpose of the information is threefold:

1. To validate statements he has heard
2. To clarify statements which are unclear or confusing, and
3. To explicate the purpose of protocols, programs, service, and health care related matters[3]

It appears to me that an informed patient/client makes it possible for the professional relationship to have substance. When people work together, energy is generated that was not there when they worked by themselves. Perhaps, this is part of the reason that mystique is generated in the physician-patient relationship. Within the helping process, bonds of trust evolve. What better way to encourage the development of trust than through mutual regard and exchange? Openness of information resources will help the layman to achieve his purposes and to make him better able to engage in relationships which promote his ability to be producer of his own health care.

We have been asked to approach this topic from the area of health science represented by our professional discipline. Social work's area of concern is the social functioning aspect of the human life process. In order to carry out this area of concern, social workers pay attention to the person-in-situation. From this professional perspective, it seems to me that in order to select, acquire and disseminate information, the librarian must be aware of the characteristics of the persons who are seeking and utilizing information, the situations which bring them to the library for information, and the interaction which takes place between the person seeking information and the person providing information. Moreover, when the person is in the library, what attention is paid to the nature

of the information being sought and the means that are utilized to provide it. In the program narrative for this institute the following statement is made: "The layman will approach the library which most nearly matches his perception of the natural place to go in order to receive help with his information needs." This statement echoes social work's concern for the person, the situation, and the transaction which takes place in the helping process.[4]

I want to take the sentence quoted above from the program narrative for the institute and relate to its component parts from a social work perspective in the following way:

> Person - the roles he plays in health care. "The layman"
>
> Perception - the factors which influence his view of health care. "will approach the library which most nearly matches his perception"
>
> Place - the location is based on situation. "of the natural place"
>
> Process - what means are utilized to pay attention to person, perception, and place. "to go in order to receive help with his information needs."

Person

The layman who approaches the library for information may have a variety of roles which he plays when he relates to health care services. I am suggesting three interrelated roles although I am sure that there may be many more. The person may carry out one role at a time. He is likely to move from one role to another at different points in time. Patient. Family member. Consumer.

Patient Role

A patient is a person receiving care or treatment. A patient may be under the care of one or any number of health care professionals e.g., physician, nurse, social worker, pharmacist, occupational therapist, physical therapist and others. The health care professionals may work in parallel activities or in multidisciplinary groups. The patient's function is to cope with his illness or wellness. What information does he need and from whom does he receive it in order to achieve this outcome?

Family Member Role

The family is the primary social unit in our society and it is from this social system that the patient comes. In the family, there is a biological and social history. There is the expectation of future caring relationships. Through inheritance, common living quarters, shared beliefs, similiar future goals, the patient and the family look to each other for protection and support. The family may be the caretaker physically, emotionally, and economically. The patient may be at one and the same time the person being taken care of and the person taking care of others. Persons do not lose their roles as mother, father, sister, brother, husband, and wife when they become ill. The family member's function is to assume caretaking activities. What information does the member need in order to carry out this function? If for some reason the family is incapable of carrying out this function, what resources are available and acceptable?

Consumer Role

In economics the consumer is the person who uses goods or services to satisfy his needs. We have already noted that health care is an industry as well as providing for certain human service needs. The consumer has direct control over certain economic and monetary aspects of health. Everyone is in some state of health and well being. Our health beliefs, values, state or stage of life, the degree to which we are hurting influence the actions we take or do not take regarding the purchase of health services. The consumer does not have direct control over many of the fiscal aspects of health care. In recent years, consumers from all socioeconomic levels have begun to participate more actively on health care agency boards, block clubs, planning organizations, and political action groups. If the consumer's function is to plan for and to purchase health care goods and services at the individual, family, or community level, what information does he need to carry out these activities?

Perception

The layman will approach the library which most nearly matches his perception. We have already noted that the layman assumes, achieves, or ascribes different roles in health care. His perception of health and health care is influenced by the roles he plays as well as other factors. I would like to point out four factors: social inheritance, milieu, culture; hierarchy of needs; stage of life; and place in the health/ wellness continuum.

Social Inheritance, Milieu, and Culture

From the earliest handling of the child, health beliefs take shape and are expressed in the behaviors of the child's caretakers. The way a baby is handled, fondled, fed, bathed, clothed influences the attitudes of the child. The development of patterns of sleep and activity influence the way the child behaves. The environment of the home, the neighborhood, the school, the church provide a milieu in which the child grows and develops. The health habits of the family and the way that parents and siblings cope with wellness and illness are shared with the child implicitly and explicitly. Religious beliefs regarding food, life, death, sex and other matters are a part of most persons' heritage. Folk beliefs are handed down from generation to generation. Health beliefs are so much a part of the fiber of each person that they often go unrecognized. If indeed education is involved in behavioral change, it is often these core beliefs that may be subject to change. When information is provided, what do we need to take into account regarding the person's health belief system?

Hierarchy of Needs

We are familiar with Maslow's conceptualization of a hierarchy of human needs from survival needs to self actualization. The person who is at the level of survival requires answers right away. The needs of suicidal persons, rape victims, and battered women have been highlighted recently. There are people in every community who need food, shelter, and clean air. Crisis situations occur every day in the city streets and in homes. When a person's life situation moves up the ladder to self actualization, health concerns may be centered on such things as staying physically trim, finding ways and means to go to a tropical climate in January, or maintaining a certain quality of life in spite of a physical disability or terminal illness. If health education aspires to help people grow and to achieve their maxium capabilities, in what way is the education process geared to pay attention to the person's needs?

Stage of Life

Ego psychology suggests that growth continues over the life cycle. Different authors conceptualize these stages as developmental tasks, seasons, or passages. In any event, certain wellness tasks take place in each stage of life as the person grows and develops from conception through old age to death. There are thought to be age appropriate tasks which take place throughout the stages of the life cycle. As people pass through these developmental stages, information

which is age appropriate or, perhaps, anticipates future developmental stages is necessary. What is the content of such information and what is the most appropriate means of presenting it for the different stages?

Place in the Health/Wellness Continuum[5]

Every person has health of one kind or another. Health may be considered a state of being. It may also be perceived as the ability of an individual to function in a manner acceptable to himself and the group of which he is a part.[6] Wellness connotes the person's active engagement in his own health care. In the continuum from wellness to illness, the health care producer and provider is concerned with health promotion, specific protection, early diagnosis and treatment, disability limitation, and rehabilitation.[7] The person's capacity for functioning may be affected by all of the factors previously mentioned as well as his state of physical, mental, or social wellness or illness. The person's need for information about the natural history of a disease process is different if he is at the point of early diagnosis and treatment than if he is at the point of terminal illness. Prevention which aims to help the person function at his highest level no matter where he is in the health/wellness continuum, necessitates the provision of and the taking in of information which promotes functioning. Some information should relate to anticipatory actions which might prevent further breakdown. Perhaps it is in this area of the health/wellness continuum that all of our questions about what and how to give information finally come together. Our sensitivity to the person-in-situation, to his needs, to professional helping persons' rights and responsibilities comes to the fore in this factor.

Place

The layman will approach the library which most nearly matches his perception of the natural place. The roles the person plays and all those factors which influence the person's perception go to make up the natural place. We need to ask where is the person in place: at home, in school, at work, in the hospital, in a nursing home, in the physician's office, in a health spa?[8] What is the natural place for a person to go? We take into consideration his roles, his health, beliefs and attitudes, his life needs, his stage of life, and his place in the health/wellness continuum. Does the information come to the person through mobile units in the hospital or neighborhood or does the person go to a place where books and other informational materials are housed? What resources are needed

to make the place available, accessible, and acceptable?[9]*

Process

Finally, the layman will approach the library which most nearly matches his perception of the natural place to go in order to receive help with his information needs. The process of receiving and giving help is identified last but may need to be one of the first considerations after need for and access to information have been determined. The art and science of giving help is the essential core of the social work profession which I represent.[10] I believe that it is an essential element of all professions which deal with people. Librarians undoubtedly receive specific training in the helping process. To give help connotes the reciprocal action of receiving help. We might ask if health educators are paying attention to the reciprocity of actions which take place between the giver and the receiver? Is information provided about the helping process itself both for the health professional and for the client/patient?

Summary

This paper deals with the layman's need for and access to health information. It is presented from a social work perspective. It relates to social work's area of concern for the social functioning aspect of the human life process and to the person-in-situation. Education is viewed as a transactional process in in which behavioral change takes place. The client/patient is perceived as the producer of his own health care. Certain characteristics and conditions of health education are suggested for further exploration. The purpose for obtaining information is suggested. A sentence from the program narrative for the institute is broken down into its component parts. Comments and questions are raised from a social work perspective related to person, perception, place, and process. It is the hope of the author that the abstract concepts presented may serve as a jumping-off place for the librarians attending the Institute to move to a more definitive level of practice.

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*Four interrelated basic conditions are proposed which are necessary to satisfy the health needs of people and to develop and cherish the human resources necessary to meet these needs.

The four conditions are availability, accessibility, acceptability, and accountability of health service systems for the nature, quantity, and quality of health care provided.

Availability entails a shift from a primary focus

on episodic medical care to care oriented to the whole person and his needs for advancement of health and for disease prevention, as well as for treatment of diseases and disabling conditions.

Accessibility means structuring of health service delivery so that people may enter and remain in the mainstream of health care without discrimination based on the social, economic, race, ethnic or cultural components of their life-styles.

Acceptability requires that health care delivery systems be directly responsive to the dignity of every man, and to consumer interests. Consumer interests include concern with standards for the quality of the various parts and the whole of health care. They include the organization of health care around the needs of people and not primarily around the convenience of health professionals, or that of institutions or agencies which provide service.

Accountability means that providers of care and the systems of which they are part are directly responsible to consumers for the previously outlined availability, accessibility, and acceptability, and for full disclosure of the sources and uses of health dollars. In addition, health service organizations are responsible for interaction with other social and environmental systems which affect health, health care, and man power.

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PATIENT/HEALTH INFORMATION--THE LIBRARIAN'S ROLE: ONE PERSPECTIVE ON HOW PUBLIC LIBRARIES CAN ASSIST IN DELIVERING HEALTH INFORMATION TO THE PUBLIC

Norman L. Maas

Health Information and the Public

There is little question that the public in America needs better health related information. What exists, however, is a real failure on the part of the government, the medical profession, medical libraries, public libraries, and other concerned groups to systematically disseminate this information to the public. Perhaps the words "concerned group" are giving everyone involved far too much credit in that, if all involved had interacted and performed their job well, an efficient delivery system for health information would already exist.

Why are not easily readable pamphlets available on many health related issues? They should exist and be available in adequate quantity to truly meet the need for this type of information. Also, the public should know where it can obtain them. For example, where is there an adequate source of information on types of birth control? The same question can be asked about drug and venereal disease information. Unfortunately, this information is not readily available to the public other than through a few agencies who often do not have well formated information, and certainly not in sufficient supply. Again, to whom does one turn for assistance in locating this information?

Since this situation exists, it is imperative that a better system be developed so the public has good access to basic health information. Public libraries can assist in this task by functioning as community information centers. At these centers, pamphlets on contraception, venereal disease, drugs, and all types of health issues can be given out to the individual, or the person can be referred to the appropriate agency for this information. Naturally other sources of information currently exist in libraries and will also be used in answering health related questions. This requires

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that all "concerned" with health information work together with public libraries to achieve this objective. Public libraries exist across this country, often having numerous branch outlets. It only makes good sense to utilize these libraries as disseminators for this type of information.

Public Libraries as Community Information Centers

Not only is health information difficult for the general public to easily obtain, but so is a wide variety of other types of information and services. At the present time, there is no nationwide uniform system that directs people to sources of information and/or services. If public libraries decide to assist by providing such direction to health information, as well as any information and/or service required, they will need to clarify their own goals and objectives and prepare their staffs to function as information and referral agents. In addition, certain basic concepts and procedures will need to be clarified.

Library staffs must incorporate into their role as professionals increased responsibility in guiding the public to any information and/or services being sought. Such information or services may be contained within the confines of the public library, available through non-library agencies, or be a combination of both. It is the task of the community information center librarian to direct the public to any of these areas. The public library thus increases its responsibility to serve the total informational needs of the public, rather than strictly make available the materials it acquires and distributes.

It is imperative that the staff and the library administration recognize the importance of playing such a role on a constant versus an incidental basis. Continuous rather than sporadic guidance will determine whether or not the public will view the public library as the information center in a community. If every time the public contacts the public library, good informational guidance is forthcoming, the public will learn to view the library as the place to go for such direction. It is up to the library to build its image as an information center with it's own staff as well as with the public it serves. This can be accomplished by: (1) Administrative commitment not only in philosophical and verbal support, but in concrete actions; (2) Continuous staff training, including regularly scheduled workshops, etc.; (3) A mechanism to insure that these roles are being fulfilled; (4) A well-planned advertising campaign keeping all members of the community constantly aware that the library exists to serve their informational needs, it is their information center; (5) Adequate staff resources devoted to community information

development.

The Detroit Public Library began in 1971 to plan to provide such a service. Detroit's community information and referral service is called TIP, an acronym identifying the library as "The Information Place." Since June, 1973, Detroit's information and referral service has been included in all of its twenty-six branches as well as the Main Library and is available by telephone and in person. Every branch library now functio s as its neighborhood's information center and the res onse by both the public and human service providers has bee excellent. Using the library's total informational resources, as well as the newly developed community information file, the librarians use their traditional library skills of listening to and interpreting people's informational needs so that they can direct them to essential human services or any other information and/or services desired. Doing what librarians have always done best--gathering, processing, and disseminating information--Detroit librarians are performing these tasks to "map out" or "index" the route to various non-profit services, agencies, organizations, clubs, groups, etc. Active assistance, follow-up, and continued interest in satisfying individual requests are integral to this professional library service.

A Basic Question

In conclusion, it should be mentioned that a current emphasis of the TIP service is searching out appropriate pamphlet information to put into all branch libraries on critical topics, including health. Finding this information,as mentioned earlier, in a useable format (appropriate reading level, length, approach) is difficult. One of our goals is to obtain this information in handout-quantity to place in branch libraries. From the difficulties we have experienced, it is only reasonable to ask,"Who is genuinely concerned about this problem, and who is responsible for making sure this health information does exist, and is readily available?"

PATIENT/HEALTH EDUCATION--A MEDICAL SCHOOL LIBRARIAN'S PERSPECTIVE

James F. Williams, II

Introduction

> A current belief in this nation is that the "crisis" in American medicine could be solved by the primary expedient of educating the public about its health . . . The fact that this whole thesis is trash has less to do with medical care than the dynamics of communications. Far from being ignorant, Americans are bombarded with too much information on too many topics.[1]

If there were general consensus on this writer's beliefs, there would be no call for a national conference on patient/health education. Suffice it to say, however, that Dr. Halberstam's is not the minority view and that opinions are polarized on whether Americans are adequately educated about health. By way of definition, it would appear that health education is not always considered in its full context. In order, therefore, to establish a common perspective on the breadth of health education for the purposes of this paper, the following definition is offered:

> . . . health education is a process that informs, motivates, and helps people to adopt and maintain healthy practices and life styles, advocates the environmental changes needed to facilitate this goal and conducts professional training and research to the same end.[2]

As the movement to improve health planning at the local, regional, and national level has created agencies that require at least 50% consumer participation, definitions like the above further suggest that the content of health information must extend to information about (1) personal survival in

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relation to illness and disease, (2) the nature and availability of existing health services, (3) the role of environment and work in influencing health and disease, and (4) the provision of information that people can use as they play a role in deciding what kind of health programs and services they want in their communities.[3]

Factors Influencing the Health Education Movement

Several factors led to the growth of the present health education movement in the United States. These may be divided into personal health and health system factors which include, but are not restricted to, the following:

Personal Health Factors

1. Medical Technology-- the discovery of insulin and the introduction of home treatments such as dialysis where the patient joined the health care team and had to be educated.

2. Affluence-- we no longer have to worry about crippling and killing diseases of the past like polio, small pox and typhoid fever. Our major health problems are now with diseases like cancer, heart disease and cirrhosis of the liver caused by cigarette smoking, obesity or alcoholism. Just as we have vaccines to prevent those earlier health threats, there are those who think that education can prevent modern diseases.

3. Consumerism-- the emergence of Ralph Nader, women's liberation, diet fads, etc. resulted in books, newspaper/magazine articles, radio/TV shows, etc. on communicating with your doctor, self-treatment, warning signs of cancer, no-smoking campaigns, physical fitness, etc. The trend was to give people a say and more education. This saw, for example, consumer participation as a requirement on health planning boards, i.e. Health Systems Agencies (HSAs).

Health System Factors

1. Cost Containment - with the consistent pattern of exponential yearly increases in the cost of health care, agencies like the American Hospital Association and insurance companies became interested in health education because of its cost benefits. Ignorance as to the source of many illnesses and accidents received increased recognition and the belief that health education can reduce costs was promulgated by

respected authorities.[4]

2. Malpractice - as a reaction to mounting law suits both the American Medical Association and the American Hospital Association called for more health education in the mid-1960's; informed consent laws were passed and widely applied and, as a further reaction to legal hassles, the American Hospital Association adopted the Patient's Bill of Rights in the early 1970's (in which 12 of the rights deal with patients being informed).

3. Government Regulations - the following government related events would appear to constitute influential factors for the growth of health education:

   a. 1973 - Public Law 93-222, the Health Maintenance Organization (HMO) Act was passed and stated that HMOs should encourage and provide health education programs for their members.

   b. 1974 - The Bureau of Health Education was established (HEW) and provided, among other things, grants to initiate health education programs.

   c. 1974 - Public Law 93-641, the National Health Planning and Resources Act, was passed, outlining health education as one of the ten national health priorities.

   d. 1975 - Establishment of the National Center for Health Education (HEW).

   e. 1976 - Public Law 94-317 (Title I), the National Consumer Health Information and Health Promotion Act, was passed providing, among others, grants to initiate health education programs.

   f. 1976 - The National Health Promotion and Disease Prevention Act was passed, giving the Secretary of HEW specific authority to foster health information and health education programs.

   g. 1976 - Establishment of the Office of Health Information and Health Promotion in the Office of the Assistant Secretary of Health.

   h. 1978 - The move towards national health insurance, whose preparations include incentives for prevention.

Potential Providers of Information for Health Education

Besides libraries, the list of potential providers of information for health education includes, but is not limited to, the following:

A. Dentists

B. Drug Companies

C. Federally mandated health related bureaus of HEW

D. Free Clinics

E. Health Educators

F. Health Maintenance Organizations

G. Hospitals

H. Institutes of National Institutes of Health

I. Insurance companies

J. Magazines

K. Medical supply companies

L. Municipal health departments

M. Newspapers

N. Nurses

O. Physicians

P. Public schools

Q. Radio

R. Social workers

S. Television

T. Voluntary health associations

U. Whole range of middle health workers

While this list leaves considerable room for expansion it provides enough of an example of why librarians have not come forth with an authoritative definition of the most effective means to disseminate information for health education. Coupled

with the length of the list of potential providers, librarians are faced with the fact that the media (predominantly TV) is the primary source of health information for the public, with physicians holding a distant second.[5] This situation is exacerbated by the fact that only 30% of the information received via TV is useful[6]; and the fact that messages received via TV rarely have health as their major emphasis.[7] Faced, therefore, with the number of potential health information providers and the fact that the public's primary sources for such information are the media and physicians, what role should libraries play in the provision of information for health education?

Libraries and Information for Health Education

In 1976, a national Task Force for Consumer Health Education (speaking in terms of a specific locus of responsibility for health education) recommended that:

> ... for the nation as a whole, hospitals and other health care institutions provide the most practical and universal site for fixing responsibility.[8]

This statement obviously had direct implications for health sciences libraries in hospitals. It should be noted that across the nation, many hospitals and their libraries have met the challenge of this recommendation and established health education centers and/or collections for patient and public use. While not disagreeing with the recommendation on the locus of responsibility for health education, it must be stressed that the public, particulary the public in good health and/or the public with ill relatives, does not always think of hospitals and other health care facilities as the place to acquire health information. For a large majority of the public, the public library is perceived as the best source. And, when the public has exhausted the resources of the public library and require yet more information, public librarians do not always perceive of hospitals as the next best source of referral; it is not uncommon for the public to be referred to medical school libraries. While medical school libraries may own medical reference works written specifically for the public (in many cases the same ones owned by public libraries) which are consulted along with other medical texts, dictionaries, etc. when handling a query from the public, the predominance of their collections is devoted to treatises on clinical medicine and the full range of biomedical research. Those items in the collection that deal with the subject of health education are more likely to be aimed at the health professional being trained to plan, develop, coordinate and evaluate the appropriate methodologies which should be applied to health education programs. If, after referral from the public library, the health information needs of the public cannot be satisfied

via the medical school library's collections, yet another referral is necessitated; such referral still may or may not involve a hospital or other health care facility, depending on a reference librarian's knowledge of local or other sources. This brings us back, full circle, to the aforementioned list of potential providers of such information, and perhaps to a patron whose level of motivation to seek useful information has been depressed.

While this example of the possible referral route which may be taken by the public for health information is exaggerated, any plans for the dissemination of such information via libraries must take into consideration the public's and librarians' perceptions of libraries and the types of information they house. Considering the vast number of sources of health information (whose messages may or may not be accurate) and the fact that this situation is not particular to only one sector of the country, for those persons motivated to seek health information from libraries, this becomes an information and referral problem of national dimensions.

The role of librarians in the process of health education is to assist citizens to obtain information on (1) disease prevention, (2) health maintenance, (3) entry into the health system, and (4) maximum utilization of existing health services. In order for the nation's librarians to (1) assume their role of providing information and referral with regard to health and (2) assist the national health effort to produce self-reliant health consumers, the following would appear necessary:

A. The establishment of closer professional ties between public and health sciences librarians. This should be done to the extent that each group is (1) aware of the other's resources, (2) aware of the other's service capabilities, and (3) actively sharing information about new resources. While this is possible to accomplish at the local level (and local efforts should provide the model) the need to establish such ties is a national one and the issue should be perhaps addressed via joint efforts of the professional associations of public and health sciences librarians.

B. The development of a national system to guarantee the existence of health information materials, e.g. books, pamphlets, audiovisuals, etc. which have been written by health professionals and reviewed/recommended for public use by a panel of peers. The establishment of such a system would appear to be an appropriate task of the Office of Health Information and Health Promotion currently situated in the office of the Assistant Secretary for Health.

C. To the extent that a large number of health information materials are produced by the categorical institutes of the National Institutes of Health and other health related bureaus of the federal government, the National Library of Medicine (NLM) should assume the role of bibliographic authority for those materials; in this capacity NLM should make its data base of such bibliographic records publicly accessible via printed/on-line catalogs.

D. In conjunction with the proposed evaluatory role of the Office of Health Information and Health Promotion, NLM should produce a national data base which identifies the producers of health information materials and the nature of their products; this data base should be searchable by subject and made publicly accessible via printed/on-line catalogs.

E. Both public and health sciences librarians must begin to share a portion of the blame for the lack of bibliographic control among health information sources; the suggestion is that these librarians must begin to take a proactive role in working with procedures of such materials to convince them of the necessity for appropriate information from which to build bibliographic citations.

Summary and Conclusions

The best description of the current practice of education for health care is perhaps that it is a field in transition. On one side there is the excitement of emerging programs, new professions, new federal bureaus, growing research, and the availablility of grant funds to experiment with new methodologies. On the other side there is a lack of common goals and objectives, a variety of uncoordinated, duplicated programs, and an inadequate number of professionals in the field. On the library side there are the myriad sources of information for health education and the strong need for public and health sciences libraries to perform as libraries' libraries in the provision of information and referral to the public on matters of health. It is patently clear that the locus of responsibility to define the mechanisms which permit librarians to assume their supporting role in health education rests with librarians. The challenge of this conference is to reach consensus on such definitions.

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EMERGING PATTERNS OF INTERLIBRARY COOPERATION: A BACKGROUND SKETCH

Genevieve M. Casey

Perhaps the most important insight of this institute is that consumer health information is a concern of all types of libraries, especially medical, hospital, and public libraries, and that all libraries need to work together to provide our communities with the information services needed in this vital area.

Our charge this morning, therefore, is to examine alternative patterns of cooperation between libraries of different types, between libraries and other health information centers, and between local libraries and state and national networks.

Whenever I think about interlibrary relationships, I remember the late Frederick Lewis Allen, critic and editor of Harper's Magazine, who in an effort to insure his immortality invented a law, as elegant in its simplicity as it was broad in its applicability: "Nearly everything is more complicated than most people understand." Surely Allen's Law is basic to a consideration of library networks.

Before we focus this morning on specific patterns of library cooperation for the delivery of consumer health information, it may be useful to review the current state of library network development generally.

As you know, the National Commission for Libraries and Information Science (NCLIS) developed a plan for a national network to pull together all library resources in all public and private libraries in the nation, in order to make these resources available to all Americans who need them, regardless of where they live or what their educational level or with what library they are affiliated. The National Commission's plan undertakes, essentially, to connect emerging or already in place state networks with multi-state and special-purpose national networks such as the Regional Medical

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Library Network. Although the NCLIS plan may change in many details before it is finally implemented, a dramatic development in library networks has begun within the last ten years and continues to expand.

Networks, in my context this morning, can be defined as those cooperative structures which cross jurisdictional, institutional and often political boundaries to join, in a common enterprise, several types of libraries; medical, hospital, public, school, and special. What the role of your libraries may become in the emerging intertype library networks, we shall examine together.

John Cory, formerly director of the New York Public Library, once identified four generations of library organization. The first generation is made up of more or less autonomous local libraries - the library of Bon Secour Hospital, or Marygrove College, or Horace Moon School, or the public library of Royal Oak, Michigan, for example. The second generation is the single type-of-library cooperative, the public libraries in a region or a consortium of hospital or academic libraries. The third generation, John Cory saw as the intertype library network defined above. Still largely on the horizon is his fourth generation, a network which includes not only libraries of several types, but also non-library information centers.

John Cory's third generation, the intertype library network, a major library development of the late sixties, is commonly an interface between more or less highly articulated single type-of-library cooperatives.[1] By the mid-sixties, the "second generation" single type-of-library system, while not universal throughout the states, was quite firmly in place, especially in the minds and aspirations of library leaders. According to Stephen McCarthy,[2] then executive director of the Association of Research Libraries, there were over 1,000 consortia of various kinds and purposes among higher educational institutions in the United States, many of them involving libraries. Charles Nelson, in his study of public library systems in 1968, identified over 1,500 cooperative, consolidated and confederated systems.[3] The affiliation of local and regional medical libraries with the National Library of Medicine is another example of these unitype systems. A convergence of many factors in the late 1960s brought about the evolution of unitype into intertype library networks.

The first of these factors was pure necessity - the inability of libraries to cope individually with exponentially increasing materials, with collections which doubled at least every sixteen years, mandating an endless increase of space, with skyrocketing costs even beyond inflationary rises in the rest

of the economy. Figure I charts the increase in American Book Production alone, from 1880 to 1973.

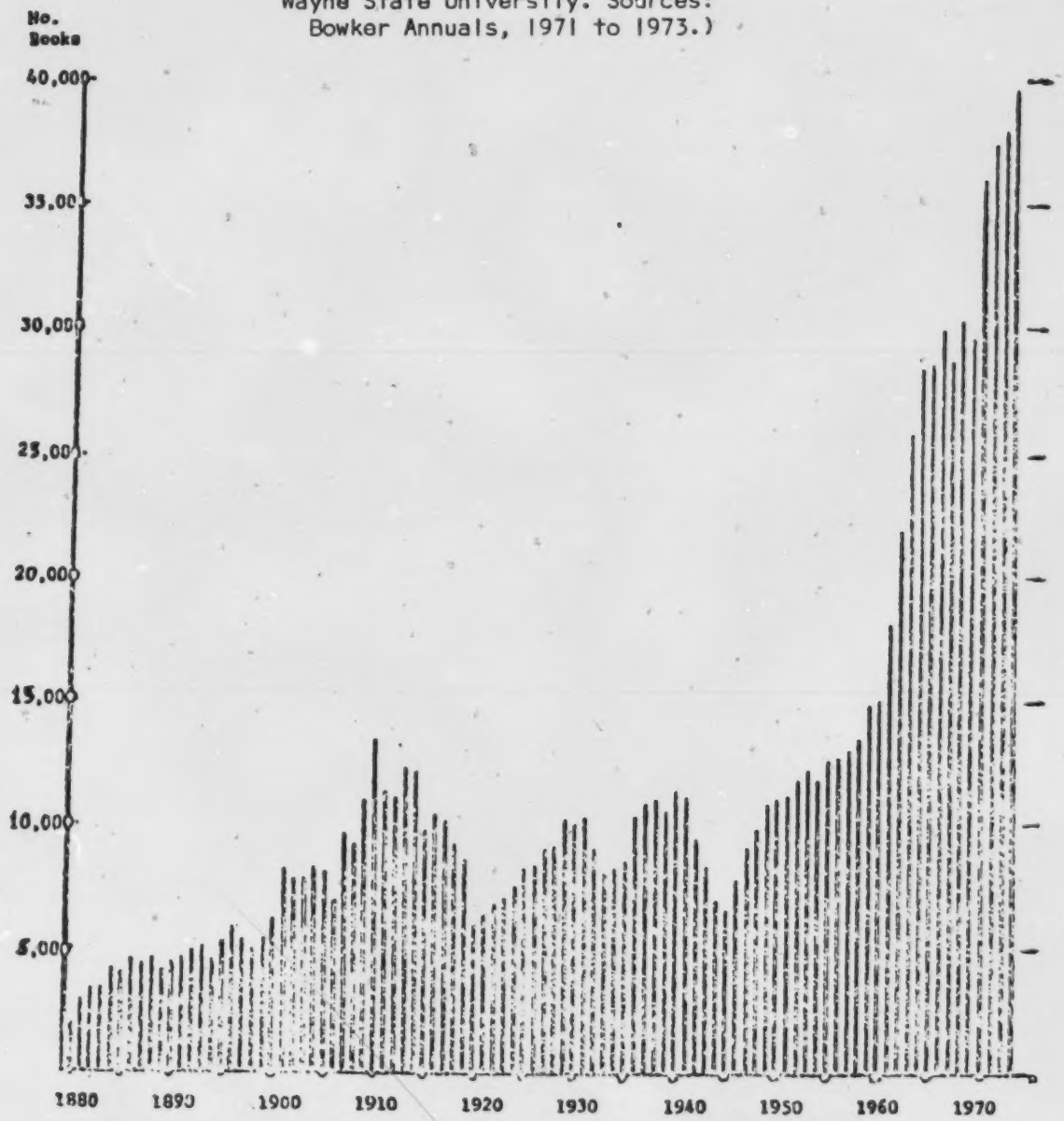
The second converging factor was the development of technology capable of dealing with some of the major obstacles to intertype interlibrary cooperation - geographic distance, diversity in method created by a diversity of mission, a tradition of autonomy among libraries of all types and the overwhelming complexity of the human record itself. Perhaps more important than the availability of suitable hardware was the fact that, in the mid-sixties, the library profession attained some mastery over the intellectual problems presented and made soluble by machines. Underlying much of the revolutionary progress in intertype library networks was the development at the Library of Congress of MARC, cataloging information in machine readable form, capable of complex computer manipulation and of dissemination over telephone wires. The 1960s initiation of the MEDLINE program provided on-line access to the voluminous records in the National Library of Medicine.

The third factor which accelerated intertype library networks was the incentive of federal legislation. The Medical Library Assistance Act and the Heart/Stroke/Cancer Legislation created a network of regional libraries with the National Library of Medicine, to make health science information accessible through the smallest local library. The Higher Education Act of 1965 under Title IIA encouraged academic libraries to form consortia and jointly plan for the acquisition of library materials. The Elementary and Secondary Education Act of 1965, Title II, required that state plans include some provision for coordination between school libraries and public libraries at both state and local levels. However, the most significant stimulation to intertype library cooperation came with the addition of Title III to the Library Services and Construction Act in 1966.

Title III, LSCA, provided funds to the states to "establish and maintain local, regional, state or interstate networks of libraries for systematic and effective coordination of the resources of school, public, academic and special libraries or special information centers". The legislation mandated that every state develop a plan with the help of an advisory council representative of libraries of all types, a provision that in many states created the first real interaction between all library interests and put the state libraries in the center of intertype planning. Funds could be spent for equipment, personnel, leasing of space, communication, but not for materials, a wise prohibition since it forced the linkage of existing resources with the traditional shared use of a collection of expensive and/or esoteric materials.

FIGURE 1

American Book Production: 1880 Through 1973
New Books and New Editions
(Prepared by Dr. Betty Maurstad,
Assistant Professor, Library Science,
Wayne State University. Sources:
Bowker Annuals, 1971 to 1973.)



Title III required that federal funds be matched on a 50-50 basis with state or local funds. Although authorizations under the Act were substantial, actual appropriations have been minimal, enabling only basic grants of approximately $40,000 to each state each year, a sum which cannot begin to fund the massive programs needed.

Despite its minimal funding Title III LSCA has played a significant role in the development of intertype library cooperation. For the first time, all of the states have taken a comprehensive look at all library resources and services in the state from the viewpoint of the user. Most states have designated "resource libraries", usually the major public and university libraries, and many have worked out some formula for reimbursing lending libraries.

As James Igoe observed after reviewing the early Title III reports, the five most common forms of intertype library cooperation under Title LSCA III, in order of frequency, have been: (1) Telecommunications networks, (2) interlibrary loan and reference networks, (3) studies or surveys, (4) union catalogs, and (5) cooperative centers for technical processing.[4] More recently shared catalog networks using such systems as OCLC (the Ohio College Library Center), BALLOTS and others are shaping libraries to new levels of cooperation. All states are now required to develop long-range, five year plans for intertype, statewide library networks,

The degree to which these three converging factors -- economic necessity, technological advance and federal incentives -- have stimulated intertype library cooperation is dramatically reflected in the increase of library literature on intertype library cooperation. This literature documents that intertype library cooperation is widespread throughout the country, that statewide rather than multi-state networks are most usual, and that there is concensus among library planners that cooperative ventures are not substitutes for strong local libraries, that successful networks must be built on strength.

As Ralph Stenstrom comments in his analysis of library cooperation literature, "while many informal agreements of long standing continue to govern cooperation, the trend is toward more formal arrangements, directed in many cases by permanent committees or councils. Interlibrary loan and communication channels are more clearly delineated; positions such as interlibrary cooperation consultant are becoming full-time permanent staff positions in state libraries; and regional councils are assuming a more important place in planning for cooperation."[5]

Within the context of rapidly developing state and regional

intertype library networks, and an emerging plan for a national library and information network, we shall explore together this morning the mechanisms already in place, and those we should invent in order to deliver lay health information to all Americans, wherever they live, and whatever their educational background.

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HEALTH EDUCATION FOR THE PUBLIC

Harold M. Schoolman

There is little doubt that ever increasing pressure is mounting to provide health information to the public. Although the response has been ad hoc, disorganized and chaotic, it has been active. For example, a cursory search of titles in the NIH "Research Awards Index" for fiscal year 1977 reveals the following:

Nationwide alcohol abuse and alcoholism advertising campaign

Arthritis center: Development of educational programs for patients with arthritis

Diabetes research and training center: Nutrition program

National search for youth initiatives in drug abuse prevention

Comprehensive center for sickle cell disease: Public Education

Health education strategies for hypertension control (doctors, nurses, patients)

National heart and blood vessel research and demonstration center: public education

Community health education extension service

Patient education film with family and learner guides

Comprehensive sickle cell disease center: community services and education

Vermont Lung Center: Group patient education. Breathing workshop

Identifying and easing the reading demands of the aged

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Implementation and evaluation of a community-based arthritis education program

Diabetes research and training center. Home health aides as patient educators

Long term elimination of chronic smoking behavior

Research center in mental retardation. Parent training

Self-management systems for asthmatic children

Effect of parent education in pediatric practices

Orienting patient and therapist for improved services

General clinical research center. Education of patients on coumadin therapy

Two methods of dietary education on weight reduction in diabetes (human)

Self-help techniques in the treatment of alcoholism

Converting alcohol education programs to 16 mm films

Distribution of NIAA publications in supermarkets

Cancer answers and rights information system

Cancer control outreach program at Fox Chase. Health education programs for the public

Telephone cancer information service

Atherosclerosis behavioral and epidemiological studies. Community media campaign

The impact of hypertension information

National high blood pressure education program

National multicultural drug abuse prevention resource center

Development and validation of model educational program. "Drug abuse and health"

Drug abuse booklet for children ages 8 to 10

In recent years, there have been appointed commissions for various diseases or subject areas, e.g., diabetes, arthritis,

nutrition, digestive diseases. Without exception, these commissions have recommended the development of "clearing-houses" for information for the researcher, practitioner, patient and public. A number of these "clearinghouses" are already in existence and more will soon be created.

These samplings from the programs of one agency--an agency that does not regard public health education as its primary mission--indicate, at the very least, the diversity of efforts carried out under the general heading of "patient education". There was a time when "patient education" was typified, and limited to, a rack of life insurance company pamphlets in doctors' waiting rooms plus, perhaps, a dog-eared collection of Hygeia .

The pamphlets are still with us, but the tools and techniques for patient education have grown tremendously, in number, complexity, and cost. A discussion of techniques for patient education today might properly include:

Telephone dial-access systems--e.g. TEL-MED

Teletype dial-access systems for deaf patients

Braille-teletype dial access systems for blind/deaf patients

Closed circuit television, in waiting rooms or individual patients' rooms

Videotapes may be located at the individual hospital or, in at least one city, broadcast from a central station over Instructional Television Fixed Service (ITFS).

The possibilities of cable television have barely been tapped, especially the newer forms with provisions for user interaction.

Office copying machines can be an important part of patient education. H. Winter Griffith's Drug Information for Patients is designed for loose-leaf format so that pages can be removed and copied for patients.

Cassette players are used in doctors' offices--a form of Medical Muzak. Another form which has been proposed uses television terminals with patient education messages in train and bus stations.

Computer-assisted instruction is being used at the Massachusetts General Hospital, for parents of children under 5. The program is called "The Number One Killer" and deals with automobile accidents.

But within this activity there is little, if any, attention

being paid to the fundamental problems of information management.

a) There does not exist even an initial general effort to define the scope and coverage of the corpus of information of concern. Are we talking about a Department of Agriculture pamphlet on how to do home canning and avoid Botulism or an H.U.D. publication on home construction, insulation and proper ventilation, or a CDC publication on the life cycle of Schistosoma Mansoni, or an economic forecast on the price of hamburger?

b) For whatever corpus of information we choose to define, what basis exists or should exist to assure reliability and currency? In the serial biomedical literature we have relied upon the various editorial review methods employed by scientific journals including referee review of peers. When we began to try to deal with the audiovisual literature for health professional distribution it was necessary to establish a quality assurance mechanism to guarantee at least minimum standards of technical and content quality. Prior to this, none existed. But in addition, there was an additional problem introduced with the audiovisual literature, namely, availability. The AVLINE record attempts to guarantee the conditions of availability and will not accept an item unless it is available.

c) Bibliographic control. If a corpus of information is defined, some minimal quality assurance mechanism instituted, and the availability of the material determined, the next unanswered question is how does one identify it? Except for that portion of patient and health information literature which is published through formal channels (basically commercial publishers) and thus because of the publishing channel a formal bibliographic record is created, no mechanism exists for any semblance of bibliographic control. There has been little discussion and no action as to what the nature of the bibliographic record should be. It seems reasonable that for such ephemeral literature some bibliographic record which is greatly simplified over that employed for the professional literature in the field should be devised. But where and how to begin? For a large amount of this literature there exists no meaningful title, no unambiguous author, no single identification number and frequently not even a date.

d) Distribution. This non-defined corpus of literature for which there is no quality assurance and which is

for the most part impossible to identify, must now be acquired, stored, retrieved, and delivered to the ultimate user; in the case of patient educational materials, some 10 to 50 million people and for public education some 160 million more or less. How can it be done and who is going to do it?

So far I have attempted to identify some of the major problems. Solutions to these problems are not readily apparent but certain actions which would begin to approach the development of solutions certainly can be suggested.

Some realistic feeling for the scope and coverage question might be acquired by a coordinated review and synthesis of the directives and aspirations of the many private foundations, government agencies, clearinghouses, presidentially appointed commissions and professional societies. Although it is unlikely that any of these organizations has addressed the question with enough specificity to be truly useful there surely will be common threads to their thinking. These constitute a basis for a workable though limited model which could be an important practical beginning.

The problem of quality control might be a fundamental contribution of the many mandated "clearinghouses." Most of the private foundations and many professional societies are members of their advisory boards. The expertise, leverage and concern are present to examine alternatives and to propose possible solutions.

The design of an appropriate bibliographic record is without doubt a responsibility of the library community. The major generators of this information do not understand the problem and have no expertise to solve it. They would be responsive to a constructive plan. On the other hand, the library community should recognize the ephemeral nature of the material, the need for simple formats which can be readily standardized and utilized by non-librarian communities and the need for a simplified design which will serve the ultimate user even if it sacrifices most of the traditional needs of scholarship and librarianship.

The various clearinghouses and their constituent members might well be a means for initiating models which would maximize the collaboration between producer and bibliographer and in fact make a simple standard bibliographic record part of any publication.

The National Technical Information Service should be approached to collaborate in this effort and accept res-

ponsibility for the bibliographic coordination of government produced documents. They might also be willing to produce general catalogues or other reference tools for location of documents including non-government produced material.

Even if these suggestions all work out there remains the complicated problem of delivering documents. No institution readily comes to mind that would willingly accept responsibility for the delivery of all documents. Perhaps the principle will have to be adopted that bibliographic records will be created only for materials where some reliable organization gaurantees delivery. How can that delivery be accomplished? It is clear that medical libraries have no access to the vast majority of the potential users of this material. If medical libraries tried to undertake this load it would significantly impair their ability to perform their primary functions. Hospital libraries certainly do have a role to play, particularly regarding patient information, but it is doubtful that they can be a primary distribution point for a great deal of patient information that is designed for office visits. The private foundations consider the distribution of such material to be one of their important responsibilities. Thus they need to be built into any real contact with the vast majority of potential users. The development of a coordinated distribution mechanism involving all these elements is indeed a challenge.

ALTERNATIVE PATTERNS OF COOPERATION IN SUPPORTING, DEVELOPING, AND ADMINISTERING PATIENT/HEALTH EDUCATION PROGRAMS IN A VARIETY OF SETTINGS: THE VOLUNTARY HEALTH AGENCY

John E. Branstetter

Nowhere in this country is the consumer more actively involved in the day-to-day operation of a health care program than in a voluntary health agency. Health needs are projected through a system created by consumers for consumers. The consumer movement manages and operates the agency from outreach to the budget approval process. The staff role is to advise and consult with the volunteers in the development and implementation of programs and services. The community and its residents are the recipients of the services. However, the major point of this discussion centers around the underlying problem of access to the system. The people are unique in many ways, diverse in interests, needs, and attitudes. The educational backgrounds, economic levels, and general community interests are factors adding to the difficulty of public health outreach efforts. Community organization is indeed the key to delivery of services.

For a basic foundation of clarity in community organization, one must understand the role of the voluntary health agency in relationship to the public. Due to the limitations on our tax funded public health efforts, primarily through health departments, the total spectrum of disease is ignored to some degree. The health department concentration could very well be limited to coordination of interest with the voluntary health agency. This creates a critical need for delivery services for specific diseases. The heart, lung cancer, diabetes, leukemia, and other agencies must then mobilize efforts to reach the public with their messages and services. Because prevention and early detection are instruments of contemporary nature, these agencies concentrate primarily on educational and informational campaigns to raise public awareness. Several of these agencies also provide services of care and rehabilitation to patients of their disease concerns. Therefore, successful outreach and community support through volunteerism and fund raising are critical to

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sustained programming. Every community resource has direct responsibility for awareness of the activities of voluntary agencies. The public is you.

Detroit is a prime example of the community spirit concept as we are half-way through a five year federally funded demonstration project called Cancer Action Now. CAN is pulling together the efforts of over 60 participating agencies to fight cancer. The program interventions range from education and information, screening and early detection, diagnosis and treatment, to service and rehabilitation. The program cooperatives are in place and successful delivery of services to the public is now a reality.

However, the program has matured and we have identified a basic concern for a central information system that people can turn to for facts, referrals to participating agencies or just someone to talk to regarding such questions as:

> "Can I catch cancer from my uncle's suits - he died of cancer?"
>
> or
>
> "My mom is taking chemotherapy, does that mean she is dying?"
>
> or
>
> "Where can I go for some information about breast cancer?"

The program kicked off this weekend in local newspapers and will continue through a ten month media campaign including TV and radio spots. Because cancer doesn't affect everyone "directly", it is difficult to know when, where, and how people will need what type of information related to the disease. The campaign is promoted as a direction for people to seek out facts or just someone to turn to - this campaign promotion is symbolic of the tremendous patience and understanding required to effectively assist people in their personal battles with cancer.

My affiliation to this massive effort is public education and early detection. The American Cancer Society contract is to reach the public where they work, live, or socialize, with prevention related information. Our current philosophy is one of delivery of pertinent facts to the population most likely affected because of specific characteristics or traits. We refer to this as the high risk or target population. We prioritize our efforts by the demographics of our population - age, sex, ethnics - and their statistical likelihood to a particular type of cancer - women to breast cancer, over-40 to colon-rectum, smokers to lung cancer.

Our energies are also directed to informing the public of the hopeful side of our research efforts. Many people are already

vicitimized by cancer and are in need of medical supplies, equipment for home recovery and sometimes transportation to and from treatment. Rehabilitation is also provided to those requiring counseling or physical rebuilding programs.

As you may imagine we can only reach those who are accessible through other agencies or their own efforts. Our goal is to help each and everyone with personal, confidential, and sympathetic guidance. We work cooperatively with doctors, hospitals, public health departments, as well as through massive advertising efforts. This is not enough. There are 9000 new cancer patients in Detroit this year and most will need these services. Most do not know where to turn. Our someone to turn to campaign may help answer some questions but I'd like to think that people can turn many directions. The role of the voluntary agency is to provide those all-important linkages for information availability and the mechanisms for dispensing. This is the direction of our efforts with the Library Systems of the Metro-Detroit Area.

Program Cooperative - Agency and Library

We view this as a program cooperative with agencies of paralleling objectives --information dissemination to improve the quality of life for our public. The responsibility we assess as crucial to the cooperation is three-fold:

1. The first step is an initial exchange of information regarding the agency's role to the public and how the library can facilitate the public'c quest for information regarding agency activities or specific disease facts. Most agencies are program directed and categorize agency literature by public and professional. Professional is directed to those whose activities are centered around the highest level of technology related to the agency's focus; Nurse Oncologist training books, specific disease research findings, etc. Public is just that, general in nature for all levels of people.

2. An evaluation of public use is the second step once the cooperative effort is contracted. The primary reason for evaluation is to provide the agency with feedback as to public interest or to provide the library with an opportunity to re-align its responsibilities in the system. Major areas of review in this evaluation would be:

   a. Supply and demand for literature or films or services can provide the agency with a temperature of community reaction to disease interest.

b. With an evaluation component established, the public reaction to quality of services offered to the public can be monitored through library staff.

c. Evaluation can also provide information required for expansion of agency/library relationships to the public. Levels of need may vary from community to community and if program interests can be broadened to meet public requests, that must be considered.

3. The third step is a continued interaction between agency and library to assure that the most accurate updated information is available for dissemination.

a. Most voluntary agencies are involved in some degree of contemporary controversy related to their activities. The American Cancer Society is constantly barraged with publicity surrounding LAETRILE and MAMMOGRAPHY. The agency role is to provide libraries with updates on these contemporary issues.

b. Agency services are also constantly being upgraded, reduced or newly introduced. The public looks for access to the programs, services, or campaigns from every source of information in their community. It is vital that libraries are on the "must know" list of these areas of public service. An example would be the National Ronald McDonald Program for the housing of parents/families who have children receiving treatment in local institutions. Another example would be the someone to turn to telephone campaign in Detroit. It is accepted that members of library staffs can read but, with agency cooperation, this information could be in place prior to the first phone inquiry or a newspaper article.

c. Another need for clear interaction is the identification of other public needs. There is no doubt a great amount of dialogue generated in libraries and, as a result of agency/library cooperation, the public could stimulate new program interests or needs via the community library. We feel it to be most important, as a source of continued growth, to recognize the fine tradition of library science as a pulse of community interests. The library must feel valuable to the agencies in their attempts to identify trends or immediate needs.

Conclusion

An ideal society or community would have these program cooperatives established and thriving, with mechanisms in place to monitor, update and evaluate. However, agencies live with the reality of all public service groups, limited dollars to reach everyone with life saving information -- an impossible but enviable task that no staff is willing to admit impossible.

Therefore the reality exists that all resources must be investigated and utilized to insure the most comprehensive delivery of services to the public. The most obvious center for information services is with the library systems. The public comes to the library because it is a trusted institution bearing access to informational needs.

We must develop and strengthen the linkage that allows our interests to merge and work together. We need each other and the public needs us.

The most important communication that we receive is that of the public needs. A linkage of program cooperation between libraries and public health agencies is essential to providing services to those who need us. People in need can be desperate people; desperate for facts, understanding, and often someone to refer them in the proper direction. That is our role, but you must know who we are, what we do and where we can provide. Many people in desperate need of help are fortunate enough to get to us. Many don't. Some who get to us know exactly what they need, others are just beginning their crisis and need everything. Our role is to let them know we support them emotionally because we understand their situation, and organizationally, because we are united and mobilized to provide for people in need of our services.

We've mentioned our budget constraints and manpower shortages but we have one asset, the public and its institutions are also affected by our health concerns. We must build on those strengths.

Our major problem is limited access to the public. The library's strength is unlimited access to people. We urge that this program cooperative be developed and that the community library become an agent between public need and availability of services.

ADDRESSING THE EDUCATIONAL NEEDS OF THE PATIENT FROM THE VIEWPOINT OF THE PATIENT EDUCATOR

Rita M. Lorden

Because knowledge relieves doubts, corrects misinformation, and supplants fiction with fact, patient education is a concrete answer to the patient's right to information as outlined in "A Patient's Bill of Rights" prepared by the American Hospital Association. Further, Skipper's study of 132 patients indicated that they desired information about their illness, and thought that the doctors and nurses should supply this information.

It is basic to a philosophy of teaching patients, that the patient has a right to know, and also not know, however frustrating it may be for the educator. Since the patient is the central figure, what he wants to know and do about improving his health status is what is important. He is an active participant in his care, not a passive one. The total person must be considered: his culture, social class, religion, environment, his personal definition of health and illness, whether or not he is in crisis, and the kind of communication to which he will respond. This concept is very complex, and the educator remains co-planner and facilitator only as long as the patient wants it.

Patients who are knowledgeable and well-informed about their illness do better in the post-hospitalization period and manage to cope with their problems more effectively. The are able to plan their activities, future and family interests in a more realistic manner.

The well-informed family takes an active role in the management of the health of their family member, because they have learned, along with their loved one, about the ramifications of illness and what is expected during convalescence.

Together, the patient and his family, as a unit, are able to create a conducive environment for recuperation, and reduce boredom, loneliness, depression, anxiety, and any other

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psychosomatic factors which are the hallmarks of any illness or disability, whether acute or chronic.

This current thinking in patient education is contra archaic thoughts that the patient and the family must be shielded from any flow of information concerning the status of the patient. However, this flow of information must be evaluated and presented in a careful manner.

Patient educators offer themselves as teachers, listeners, discussants and evaluators of the knowledge that the patient and families possess. But we cannot change the patient or the family; they must change themselves. It is the patient who is sick and only he, perhaps not even he, knows how much he can change.

People can change in areas of knowledge, understanding, attitudes, things valued and appreciated, and in skills developed. But a person must become emotionally involved himself in order to be able to change. Feeling must be involved in this process.

Logically, one would suppose that values would change dramatically after a crisis such as a heart attack; not necessarily so. For instance, why do some patients continue to smoke after the heart attack? Is is because they prefer quality of life as opposed to quantity? Does the smoking improve the quality of their life or do they lack the capacity to stop?

The ideal patient is physically and emotionally ready to learn, interested in learning, curious, and motivated to make the needed changes because he is convinced that his current habits are harmful. Also, he would have a family which would be very supportive of him. However, not all patients are going to be the ideal patient. One patient may be frightened of the diagnosis and will not want to learn more about it. Another may be interested in learning, but will not make any changes in his life style to correct the problem. Someone else may not be interested at all. Family members offer these similar responses; some are interested, some are not.

An effective patient educator will support and guide the patient and family as they move through the various stages of the grieving and adaptation process. During the first stage, emotional shock, disbelief or denial will be present. If they do not believe a heart attack occurred, the teaching-learning process will not develop. Later, as the patient accepts the reality that he is sick, then he is ready to be informed of the facts about his illness and become an active participant in his care, including life reassessment, dealing with any threats to his self-image and feelings of dependency.

How important a person regards his health, coupled with his life experiences and self esteem, will affect how he views himself during his illness; and will greatly affect his learning abilities.

Barriers to learning can be manifested in numerous ways. If the patient is uncomfortable, restless, or weak, his potential for learning will be decreased. He will fall asleep in class. If the patient is a person who rejects authority, he may see the educator as another "boss" and react with hostility to any teaching. We have also encountered language, cultural, religious, and socio-economic barriers. Patients report that sometimes professionals use non-understandable medical terms and speak too fast.

At Henry Ford Hospital in Detroit, Michigan, we have a multi-disciplinary Cardiac Rehabilitation Team approach which addresses the needs of the person recovering from heart attack, open heart surgery, or those who have angina. The program is implemented by physicians, nurses, physical and occupational therapists, dieticians, and counsellors. The purpose of this is to assist the patient to reach his optimal level of functioning on all levels.

When the patient's condition has stabilized in the Coronary Care Unit, informal teaching occurs. When he is transferred to another area in the hospital, the cardiac rehabilitation nurse introduces him to the formalized teaching program of education and exercise.

Working in co-operation with the patient, she formulates a unique plan of action.

A. Assessment of where the patient is at this time.

1. How does he picture what happened to his heart?
2. What does he already know?
3. What specifically does he want to know more about?
4. What was his health status prior to admission?
5. What factors contributed to this problem?
6. How does he perceive the effect of his illness on his self-esteem?
7. How does he perceive the effect of his illness on his family?
8. Does he understand his current activity level and need for gradual progression?

Progression activities are outlined, so that he knows what should be happening and it allows him to exercise more control over his situation.

9. The patient receives a session schedule indicating the time and topic of each session.
10. Family members are highly encouraged to attend with their loved ones.

B. Evaluation of how the patient envisions his future.

1. How does he expect to manage after hospitalization?

a. Where will he go for recuperation?

Not all patients live in a family unit, many people live alone.

b. Are financial concerns being taken care of?

2. Is he willing to make needed modification in his behavior or life style?
3. Is he willing to comply with dietary, exercise, and medication therapy?

In order to make a personal commitment to change, the patient must believe that it will make a difference, that he will feel better, or be better off for making the change.

4. What is his feeling about returning to work?
5. How supportive is his family?

During the last week of hospitalization, hopefully, the patient is ready to participate in the group discussion process. This is a channel through which he can express his own feelings and needs, and gain the support of others in the same category.

The teaching plan centers on providing current information on heart attack, angina, and open heart surgery using audio visuals such as filmstrips and posters, the latest in medical literature, current newspaper articles, and pamphlets from multi-sources such as the American Heart Association.

As the causes of heart disease are discussed the patient personally identifies his own risk factors, shares ideas, and attempts to make a realistic plan for modifying harmful behavior.

Patients learn about the good and bad effects of stress on the body and the characteristics of the dynamic Type A behavior personality. Alternative ways of living and coping with stress are offered. Relaxation tapes are used. The psychiatric social worker conducts two sessions on coping with heart disease. One is geared to the patient, the other to the family.

Activities for daily living, specifically for the first two

weeks at home, are outlined and individualized. Post-hospitalization adaptation and possible signs and symptoms which may occur, are discussed in behavioral terms, so that if the patient, indeed, does experience them he would expect them either to be normal and temporary or be aware of how and when to seek medical attention.

Dietary management plans, considering food preferences and preparation, are developed between the patient and the dietician. The patient receives ample practice in selecting food from a pre-planned menu, which later can be used as future reference at home.

Several days prior to discharge, the patient performs his exercise prescription under supervision. He writes down his pulse and how he feels during and after the exercise.

These in-hospital experiences of education and exercise are preparing the patient to function at home and increase his self-confidence that, indeed, he can do it.

What is the librarian's contribution to health care and how does the librarian assist the health educator?

When I think "library", I think current trends, hot off the press publications. I think of the librarians as the people who do the research for material and make the information available to us, the health educators.

1. The librarian has an over-all knowledge of the material in the library and can recommend articles and books. Early in my career in cardiac rehabilitation patient education, the library and the librarian were my resources. The Henry Ford Medical Library and the School of Nursing Library provided the medical literature written for the lay person. Several weeks ago, I visited the public library to investigate what types of information were available. There were several current journals and newer books. But there were more older books, written before 1970. This information would be considered old.

   From my discussion, you may have gathered that we have a limited time to help the patient during hospitalization and some may not be ready to learn at that time. Learning for those individuals may occur during convalescence at home. These patients may show up at your library seeking additional information. Have current books, health journals, and audio-visuals for them. Bookstores today have many current health books and self-care books. To keep current, libraries have to supplant old information with new.

2. A current annotated bibliography of what is available to the health field would be very helpful. This means going through each new journal and jotting down new publications and a few sentences describing them.

3. Have a listing of educational materials available from commercial companies, such as Metropolitan Insurance Co., United Dairy Council.

4. It is wise to develop a rapport with the users of the library, who could very well be your informants of new and good books available.

5. Update or develop an audio-visual section. People learn well from audio-visuals. Stock it with films which can be viewed on the premises or taken out. Grant money is available to develop audio-visuals. For instance, the Helen Fuld Foundation contributed a $10,000 grant to the Henry Ford Hospital, School of Nursing, to purchase audio-visual aids for teaching student nurses.

6. Have library request forms, so that users can order specific books not in your library. Smaller libraries can align with larger teaching hospitals to borrow teaching material.

PATIENT/HEALTH INFORMATION IN THE CONTEXT OF THE CONSUMER EDUCATION MOVEMENT

Eloise C. Foster

As evidenced by this institute, various disciplines are giving increased attention to patient/health education. All participants in attendance are directly or indirectly involved in the delivery of health care. In addition, all institute participants are consumers of health care in the United States.

There has been sporadic interest in the subject of patient/health education since the turn of the century. "The term 'consumer health education' subsumes a set of six activities that:

1. Inform people about health, illness, disability, and ways in which they can improve and protect their own health, including more efficient use of the delivery system;

2. Motivate people to want to change to more healthful practices;

3. Help them to learn the necessary skills to adopt and maintain healthful practices and life styles;

4. Foster teaching and communication skills in all those engaged in educating consumers about health;

5. Advocate changes in the environment that will facilitate healthful conditions and healthful behavior;

6. Add to knowledge through research and evaluation concerning the most effective ways of achieving these objectives."[1]

The addition of the adjective consumer to the term health education reflects the importance assigned to the consumer

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role.

Today, consumers are reacting to the high costs of medical care and are beginning to express dissatisfaction with traditional modes of health care practice. Historically, the consumer movement of the 1970s can be viewed as an outgrowth of the 1960s, a period marked by challenges to existing social institutions and mores. Also challenged during the 1960s was the traditional paternalistic and authoritarian relationship between the professional and the client which did not encourage public accountability, participation, or control.[2]

Environmental factors gave impetus to consumer education in the 1970s. The public has become better educated and more knowledgeable about health care with the news media playing an important role in dispensing such information. As consumers have come to accept the inevitability of modern medical cures, their health care expectations have risen markedly. These expectations conflict with substantial problems related to the delivery of care such as equality of access.[3]

Environmental Factors

Environmental factors contributing to consumer health education can be classified as demographic, economic, educational, governmental, and legal. Each factor could be researched and documented in depth; each has served as a catalyst for the provision of patient/health information in the context of the consumer education movement. In contrast to documents of both the United Nations and the World Health Organization, the right to health care appears neither in the United States Constitution nor in its Declaration of Independence. Proper health care is essential, however, to "life, liberty and the pursuit of happiness."[4]

Demographic

Since 1960, there has been rapid growth in the national population aged 65 or over, and especially in the population aged 80 or older. These age groups cited consume four times the amount of services consumed by other age groups, per capita.[5] Diseases tend to be chronic; treatment focuses on caring rather than curing.

Economic

During the 1960s and 1970s, health manpower came to include an increasing number and array of allied health occupations employing sophisticated technology. Increases occurred in the number of health care institutions, beds, and the utilization of services as measured by inpatient days, inpatient admissions, and outpatient visits. Alternatives to hospitals as sources of health care services were sought.

The increase in expenditure for medical care has alarmed consumers and experts alike. Moreover, most national health insurance proposals would further increase expenditures. Both President Jimmy Carter's health insurance principles advanced in 1978 and the American Hospital Association's statement on Provision of Health Services Under Universal Health Insurance provide for consumer representation and participation.

Reducing expenditures for health or hospital care is a monumental effort. There is a divergence of opinion on how to approach and effect a resolution to the problem. As yet there is no clear-cut policy universally accepted for dealing with cost containment as the industry and its supporters develop the Voluntary Effort to counter government proposals.[6] Consumers have exercised limited economic control through refusal to purchase. This is one mechanism they have available for making social institutions or markets more responsive to their demands. Competition in the health care sector is seldom labeled as such but may be growing.

Educational

In The Report of the President's Committee on Health Education, the vast unmet needs for health education were identified. After a year of intense study and research, the committee emphasized that the delivery and financing of health care will be virtually nullified unless there is a simultaneous improvement in health education. This means not just supplying information about health to people but motivating them to accept the information and put it to work in their daily lives. The committee pointed out that of the 18.2 billion dollars allocated for medical and health activities by the Department of Health, Education, and Welfare in 1973, less than 0.25 percent was for specific programs in health education.

A review of the literature by Harris documents the realization that patient education can and does cause a decrease in hospital admissions, in cost of therapy, in outpatient visits, and in absenteeism from work or school. "The potential bene-

fits of health education far outweigh the costs, and the ratio of benefits to costs will almost certainly be greater than the corresponding ratios for most medical and surgical procedures directed at the same problems."[7] One of the causes of rising health costs is old-fashioned human indifference to what constitutes a good, livable life-style; indifference to the largely untapped powers of the human will; and indifference to ways of avoiding premature death or disability.[8]

Governmental

Increased governmental financing of health care services since the enactment of Medicare and Medicaid, and steady increases in the cost of health care services since the late 1960s have fostered the growth of regulation and legislation directed at the health care industry. Regulatory programs were enacted that were designed to improve the quality of care (Professional Standards Review Organizations), control costs (payment regulation), and allocate capital equipment and facilities (certificate of need, planning). Preexisting forms of regulation, such as codes and standards, licensing, and accreditation were expanded. New regulatory programs enacted by the federal government were frequently designed to include local input or public participation.[9] The Health Maintenance Organization Act (Public Law 93-222) and the National Health Planning and Resources Act (Public Law 93-641) are significant in this regard.

A Bureau of Health Education was established by the government in 1974; nongovernmental agencies combined their efforts in the establishment of the National Center for Health Education in 1975. The National Consumer Health Information and Health Promotion Act (Public Law 94-317) in 1976 relates to health information and disease prevention. All of these national activities have the potential to impact on each health care setting.

Legal

Informed consent and medical malpractice suits have been influential in the push for patient/health education. While informed consent is intended to protect physicians and hospitals from litigation, it recognizes the patient's right to information about his condition.

Consumer groups have publicized the American Hospital Association's A Patient's Bill of Rights, approved in 1973. Six of the twelve sections refer to the patient's right to obtain specific information from the physician or the hospital as

indicated below:

Section 2. Diagnosis, treatment, and prognosis (physician)

Section 3. Procedures determined necessary for the patient's care (physician)

Section 7. Needs for and alternatives to transfer to other facilities (hospital)

Section 8. The relationship between the hospital and other health care and educational facilities (hospital), and relationships among those treating the patient (physician)

Section 9. The existence of research projects that may affect the patient (hospital and physician, see 2 above)

Section 10. The patient's requirements for continuing health care following discharge (physician)[10]

Numerous hospitals have adopted the Association's bill or prepared their own statement. These statements serve to clarify the relationship between the consumer and the provider. A corollary to the requirement of informed consent is a patient's right to refuse to submit to medical treatment. The American Hospital Association also approved in 1973 the statement on The Right of the Patient to Refuse Treatment.

Responses to Environmental Factors

Hospitals have played an important role in educating the public about its health. Recognizing this role, the American Hospital Association issued a statement on Health Education: Role and Responsibility of Health Care Institutions. In part, the statement indicates that

> Hospitals and other health care institutions, as focal points of community health care, have an obligation to promote, organize, implement and evaluate health education programs. As part of this process, hospitals should plan with other health care institutions and community agencies to define each organization's role and responsibility in meeting the health education needs of the populations they serve.[11]

Again the American Hospital Association responded to the emphasis being placed on consumer health education by creating in 1978 a Center for Health Promotion to bring

together and expand upon organizational activities and programs in patient education, community health education, and employee health. The Center has focused its effort on providing support to patient and community health education programs in member institutions, expanding an employee health program for American Hospital Association staff, assisting member hospitals in developing programs to help businesses keep their employees healthy, and developing and maintaining strong liaisons with other groups and organizations involved in health promotion. Special attention is centered on identifying hospital-based programs that might serve as models for other institutions and on developing a resource file of programs and materials.[12]

Other professional and voluntary organizations have responded to new challenges and are encouraging health education by defining their roles and responsibilities. Four professional groups are cited as examples in Professional, Accreditation, and Legal Statements Supporting Patient Education: medicine, nursing, dietetics, and pharmacy. In all cases patient education is viewed as an integral part of the clinical practice.

Gartenfeld has noted a commonplace consumer response to environmental variation.

> An activated consumer brings demands for information about whatever field interests him or her. In the area of health, this has resulted in pressure on libraries not only by the consumer of information but also by the professional who must now provide it. Health sciences libraries are being asked to supply users with materials aimed at the education of lay persons as well as the training of professionals. Public libraries are being asked to add to their collections materials which they do not know how to evaluate and which are often expensive and quickly outdated.[13]

As a profession, librarianship has taken a firm stance on access to information for all persons. As stated in the Library Bill of Rights, endorsed by the American Library Association, libraries should provide books and other materials presenting all points of view. Intellectual freedom and the freedom to read movement also reflect consumer interests.

Several library-based consumer health education programs are attracting attention. At the Oakland, California facility of Kaiser-Permanente Medical Care Program, a health education library for patients was opened in 1969. The implications from this study are that there is potential for a health library for patients to be used as an educational tool by

providers of care in many settings; that the success of such an operation as a resource and learning center requires cooperation of professional staff and consumer patients; that people of all ages are amenable to this method of health education; and that further exploration in this direction would be both desirable and feasible.[14]

CHIPS (Consumer Health Information Program and Services/Salud Y Bienestar) is a Title I Library Services and Construction Act project funded for two years, 1976-78. This bilingual project is a formal cooperative program between two separate county departments, the Los Angeles County Public Library System and the Los Angeles County Department of Health Services. Focus of the project is to provide accurate, current health information and materials to the public in an area with people of diverse ethnic backgrounds.

The Community Health Information Network (CHIN) is a cooperative library network established between a community hospital (Mount Auburn Hospital, Cambridge, Massachusetts) and the six public library systems of its catchment area. The network began functioning in 1977 with funding from multiple sources. Clearly, health education is a topic which is becoming more and more important to all of us who are librarians, or who might one day be patients.[15]

Conclusion

Throughout the discussion of environmental factors runs a thread: the need for patient/health education viewed as a right by consumers and a necessity by the cost-conscious deliverers of health care. Health education programs can contribute to important health care goals, such as improved quality of patient care, better utilization of outpatient services, fewer admissions and readmissions to inpatient facilities, shorter lengths of stay, and reduced health care costs.[16] "Consumers must become partners in their own care."[17]

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AUDIOVISUAL AND PAMPHLET MATERIAL FOR PATIENT EDUCATION AND HEALTH INFORMATION

Kathleen M. Carmichael

Hospitals and the medical profession are in the midst of a growing dilemma concerning consumers' rights and informed consent. Hospital libraries find themselves in a unique position to respond to these demands.

The objective of this report is to: define the concepts, "patient education" and "lay-medicine", and the hospital librarian's role in the support of these concepts; discuss the availability of pamphlet materials; and describe some programs being utilized in hospitals.

Patient education is the direct responsibility of the primary health care professional: doctors, nurses, therapists, pharmacists and members of the allied health professions. The hospital library's professional collection must be able to support this activity. Support is achieved through the acquisition, organization and dissemination of appropriate material, print and non-print.

A study prepared for the Bureau of Health Education by the American Hospital Association in 1975 surveyed its member hospitals about patient education programs. The identified professional groups most often involved in the planning/ teaching of patient education programs were: registered nurses, dietitians/nutritionists, LPN's, physical therapists, physicians, and community support groups.[1] Where is the hospital librarian?

The hospital librarian must be seen as an integral part of the professional health care team to enable the library to function in its supportive role. At Harper Hospital, Detroit, Michigan, there is a Patient Education Department which carries out the function of educating the patient. The patients' library and the professional library support this department by acquiring the needed materials regardless of format. The patients' library acquires lay-medical material for the

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patients' use. The professional library is not available to the patient except when a "prescription" is written for the patient. The librarian does not in anyway assume an educational role. The primary health care professional is expert in patient education, the librarian is expert in how to acquire, organize and disseminate the material needed to carry out this function.

The concept of "lay-medical" is very different from the "patient education" concept. Lay medical material is medical information written or produced specifically for the layman, a non-medical person. It is written and produced in language and style to be easily understood and comprehended by the layman. The hospital library and the hospital librarian's responsibility in this area demands direct contact with the patient. Again the librarian must acquire, organize and disseminate the appropriate lay-medical material to answer the patients' needs. A word of caution, the librarian must never offer medical advice or attempt to become the patient educator. As stated previously, this is solely the responsibility of the health care professionals.

The hospital librarian provides access to lay-medical materials. The library's collection must be able to carry out this dual function-- supporter of patient education and provider of lay-medical material. The trend in hospitals throughout the United States is the development of Patient Education Departments to meet the needs of the patient while in the hospital and as an out-patient. This trend has been brought about by the public demand for lay-medical material. A growing trend in hospitals now is to meet this demand directly through the hospital library, collecting appropriate lay-medical materials to which the patient has direct access. Popular magazines, newspapers, and television have heard the public cry for medical information and have met it adequately in many cases.

It is clear that the hospital librarian must be willing to take a role of leadership in disseminating correct and useful materials to the patient.

Audiovisual materials are being produced by private industry, medical associations, voluntary health organizations, individual hospitals, and the United States government. These materials are available through purchase, rental or loan. Before venturing into the audiovisual field the librarian must keep in mind the high initial costs of setting up such a program, the on-going costs, and the impact of audio-visuals upon the patient.

Buying audiovisuals is not the same as buying a book, which is a one time, relatively low cost purchase. Purchasing audio-visual materials consists of expenditures for software and expenditures for hardware, both of which are expensive. The

librarian must be aware of the high cost and how to avoid needless waste. The important rule of the thumb is "standardization". Software is the format used to impart information. The formats are handy and can answer various needs. There are audiocassettes, monitors (television and radio), videocassettes, 35-mm slides, 16-mm films, 8-mm films, Super 8 films, filmstrips, records, transparencies, etc. The librarian must assess the hospital's need and this will aid in deciding what software formats will be used.

Hardware is the equipment that is essential for the use of the software.

Prices of Audiovisual Equipment Formats:*

All Formats	Price	Primary Formats	Price
Sounds			
Record player	$ 100- 390		
Reel-to-reel tape player	390		
Audiocassette player	60- 180	Audiocassette player	$ 60- 180
Still Pictures			
Filmstrip projector	75- 200		
Filmstrip with sound	300- 385		
35-mm slide projector (Kodak AF-3)	380	35-mm slide projector (Kodak AF-3)	380
35-mm slide with sound	440- 545		
Random access 35-mm slide projector (Kodak RA 960)	1,195		
Overhead projector	290- 190		

All Formats	Price	Primary Formats	Price
Still Pictures			
3 ¼-in. by 4 in. Lantern slide projector	$ 565- 635		
Opaque projector	550		
Microform projector	450		
Moving Pictures			
16-mm film projector	2,215-2,505		
8-mm film projector	365		
Filmloop	395		
Super 8-mm film cartridge	395		
Television monitor	995-1,375	Television monitor	$ 995-1,375
1-in. reel-to reel video tape player (B&W)	1,250		
½-in. reel-to-reel video player	2,750		
½-in. cartridge videotape player	1,430		
3/4-in. video-cassette player	3,395-6,000	3/4-in. video-cassette player	4,830-7,935

*Sources: La Salle Equipment & Visual Aids, Detroit, Michigan
Newman Visuals Education Inc., Detroit, Michigan

All prices in the table are rounded to the nearest five-dollar figure. Total price for the Primary format would range from $4,770 - 7,755. (Prices quoted as of December, 1978).

Standardization is the rule to live by so that the library will economically meet the needs of the user. The librarian must decide to standardize the audiovisual hardware to be used within the library and the hospital. Once this decision is made the software purchased is automatically standardized. A feasibility study by Brantz showed that audiovisual equipment, regardless of the format (there are more than two dozen formats), performs three basic functions:

> ... producing sound, still pictures, and moving pictures. Features such as monophonic or sterophonic sound and color or black-and-white pictures, are considered to be characteristics rather than functions of audiovisual equipment. The feasibility study also showed that the three basic functions are the same for all health science professions. Therefore the health center's administration adopted the policy that all audiovisual learning aids would be played via audiocassettes, 35-mm slide projectors, and 3/4 inch videocassettes. These three types of equipment are considered to be primary formats. All three primary formats are popular in both the public and the private sectors, so audiovisual equipment service centers are readily available.
>
> The use of headphones for audiocassette and videocassette players, rear projection screens for 35-mm slide projectors, and television monitors obviate the need for any special environment for use of the primary format equipment.[2]

There are certain things to keep in mind when purchasing hardward. It is advisable to deal with a local vendor who understands the needs and objectives of the library. All hardware should be the industrial models, not the models used for the home, since the equipment will get hard use and rough handling. It is usual that payment is made upon receipt of the hardware.

Selection of software is not as easy as the selection of a book. Previewing of software is less and less available, therefore the librarian must rely on reviews and the authority of the producer/distributor. Annotations and reviews are found in BIOMEDICAL COMMUNICATION, THE JOURNAL OF BIOCOMMUNICATIONS, HOSPITAL EDUCATORS RESOURCE CATALOG (HERC), THE HEALTH SCIENCES VIDEO DIRECTORY, AVLINE, and producer/distributor catalogs. Reviews will give intended audience; format, price, and program length. Normally when software is purchased it must be prepaid. Many producer/distributors will offer hardware at a lower price as an incentive to quantity purchasing.

Pamphlets are considered ephemeral material by librarians and they fill a definite consumer need. Pamphlets are produced and distributed by medical organizations, foundations, volunteer health organizations, drug companies, and the federal, state and local governments. They are factual, easy to read and usually deal with a specific health problem. The patient is very familiar with this type of material. Pamphlets are a good introduction to a health problem and should be used by librarians. Any pamphlet should be selected with the view toward being easy to read, easy to understand and factual. Most pamphlets are free or obtained at very low cost and should be made available at no cost to the patient.

Hospitals throughout the United States are implementing various types of programs to meet patients' needs. Probably the most widely known program is the one being carried out by the Health Library at the Kaiser-Permanente Medical Care Program in Oakland, California. The Health Library offers health and medical information to the layman. Caren Quay, head librarian, in a letter responding to a question about the use of audiovisual materials in patient education, states that this is a community service and the library users have access to audiovisual programs, books, and pamphlets as well as direct reference and referral services. Collen and Soghikian report that the Health Library at Kaiser-Permanente, Oakland, is set up to provide the following:

> ... a centralized service to which the physician may refer patients for clarification, explanation, and information leading to adequate comprehension of the nature and management of specific disease or other health problems,
>
> ... a similiar service for patients referred by nurses and other health workers,
>
> ... a health education resource for the community at large,
>
> ... an information resource available on self-referral to all members, sick or well,
>
> ... a training ground in health-related education for students and volunteers, and
>
> ... a library resource to staff members and instructors for inservice education, research, and other assistance.[3]

The Los Angeles County-University of Southern California Medical Center operates an arthritis clinic patient education library. This library is basically a bookmobile that circulates within the clinic. Swezey and Kaufman state that the selection criteria for materials include:

> Material should constructively influence patients' knowledge and attitudes about their arthritic disorders.
>
> Material should impart health information to assist patients in using the health professionals' time more efficiently.
>
> Information should not be false or misleading.
>
> Material should be at the proper educational level for the clinic target population.
>
> Literature should provide enough breadth of information to cover the various forms of arthritis.[4]

At many hospitals closed-circuit television is the vehicle used to educate the patient. St Joseph Mercy Hospital, Pontiac, Michigan has a patient information channel, TV 12. This provides the patient with regularly scheduled health information programs with a "TV Guide" given to each patient. Some of the listings are: Breast Feeding, Pap Test and Breast Examination, Don't Go With Strangers, and Your New Baby.

Mark Springer describes a closed circuit television at Ohio State University. The Ohio State University Hospitals operates "Information Please" which provides programming which focuses on 3 major areas:

1. orienting patients to University Hospitals and to the many services available to them;
2. informing patients of the procedures involved in some of the routine tests they may undergo; and
3. enhancing patient awareness of the many health care problems the flesh is heir to, subsequently noting ways to avoid illness and maintain good health.[5]

The unique feature of the "Information Please" series is the interaction component. Any questions that the patients may have concerning the program's topic area may be phoned in directly to the panel discussants while the show is on the air. Phone calls are received by nursing staff personnel and passed on to the moderator in written form. Answers are then provided by the panel.

Does the "Information Please" series help the patient to adjust to hospitalization and take an active role in health promotion? Viewer surveys indicate that 85 percent of the patients in the target area (that area which houses patients with illnesses related to the program's topic) and 35 percent of the rest of the Hospitals' census, watch the program.

Virginia Mason Medical Clinic, Seattle, Washington, uses videotape for patient education and has found that the information program lowers malpractice claims by making "informed consent" possible. The patient is given a "prescription" by the doctor to view the requested videotape or slide/tape. After viewing the program the patient signs the consent forms as evidence that the facts were given and understood.[6]

TEL-MED is a tape library of lay-medical information developed by the San Bernadino, California, Medical Society to help answer the consumers' demand for health information. The public library of Columbus and Franklin County, Ohio, has set up a health-line for the public. In the Detroit area TEL-MED is sponsored by the Wayne County Medical Society in conjunction with Blue Cross and Blue Shield. Pamphlets give a listing of topics available and the phone number to use. All the laymen needs to do is phone and request a tape by its specific number.

At Harper Hospital the Department of Libraries has a professional library and a patients' library. Audiovisual software is acquired to support the needs of the health care professionals working at Harper Hospital. The software is fully cataloged and shelved within the monographic collection. Audiocassette journals such as Audio-Digest are handled in the same manner as all the professional journals. The accompanying hardware and all software circulates in the same manner as a monograph or a journal. The patients' library at Harper Hospital has an excellent monographic collection of lay-medical materials and a small pamphlet collection which circulates directly to the patient. The library runs a bookcart 3-days per week which enables each patient to be visited once a week. The patient may come directly to the library to read, check out books or browse. The patient has direct access to the library via phone. The library staff promptly fills the patients' request, delivering requested material personally to the patient.

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HEALTH INFORMATION RESOURCE CENTERS: A COMMUNITY NECESSITY

James F. Williams, II

Introduction

It has been said that the American system of medical care is a sickness system which emphasizes disease care rather than health care; . . . while 90% of our population have some type of insurance covering hospital and physician services, relatively few have insurance that rewards the physicians for keeping patients out of the hospitals--in other words, preventive care.[1] The greatest future benefit of our present health system is likely to accrue from current efforts to improve health habits and the environment. Likewise, to the extent that most illnesses have their etiology linked to behavioral and environmental factors, individuals must be taught to protect themselves through personal preventive health care. It has been said that the health education of today shall determine the patterns of health care tomorrow.[2]

As stated several times thus far during this conference, health education is the process that bridges the gap between health information and health practices. We should hope that it motivates people to take information and put it to use in order to (1) keep healthier by avoiding harmful actions, and (2) form health habits that are beneficial. The goal of health education should be, therefore, the improved health status of the public.

Considering the speakers' presentations of the past two days and the nature of questions asked from the floor, it becomes evident that, for the vast majority of American cities, if you tried to identify who was doing what in health education and with what effect, you would find that there is no systematic approach in our cities to:

1. Foster conjoint efforts between existing private, public and voluntary health education efforts;
2. Measure the effectiveness of programs in maintaining or improving the health of the community;
3. Provide adequate tools for educating the public on health matters, including where, when, and how to use the various elements of the health care system.

In a given city there are many and various agencies, organizations

groups and individuals which play a role in the successful implementation of a community-wide health education effort. These community resources may be grouped into seven broad categories:

1. Providers
2. Government
3. Voluntary health organizations
4. Education
5. Media
6. Business and industry
7. Religious, civic and social organizations

Health Information Resource Centers

Acknowledging the fact that for most communities there is no systematic multitype organizational approach to the health education effort, it would appear appropriate to propose the need for library-based health information resource centers. These resource centers would have as their near term objective to identify community agencies with health education programs and work with them to develop a regularized mechanism to collect, retrieve and disseminate up-to-date information on:

1. The existence and availability of local people with health education expertise;
2. The existence and availability of health education program activities of various local agencies;
3. The existence and availability of print and non-print health education materials at the local level (including that in libraries).

The long term objective of these resource centers would be to develop communication mechanisms which allow existing health education programs to relate to the resources and service capabilities of their local counterparts. Information and referral protocols and patterns should then be developed as a result of these relationships.

The tasks of these health information resource centers would be those of a library; to locate, index and make accessible information about the community and its health information resources. Through the use of their data bases on people, programs and physical resources they would provide reference and referral services in order to:

1. Optimize the use of existing community based health information resources;
2. Assist in the process of relating the work of one agency to another;
3. Establish direct contact with an agency on behalf of

the public.

For the public, and perhaps community agencies, the public library is perceived as the most appropriate place to inquire about health information and the identification of local resources. Public librarians should be reminded that the primary clientele of health sciences libraries has always been, and still is, health professionals. And, while the right-to-information movement has given rise to the expansion of health sciences library services to include the patient and/or public, this is an activity with which health sciences librarians have little or no experience. It does not therefore appear inappropriate to recommend that for the nation as a whole, public libraries provide the most practical and universal site for fixing responsibility on the development of health information resource centers. A further recommendation would be that, to the extent that the ultimate goal of these resource centers is to assist the effort to relate the work of one community agency to another for the public good, it would appear that their source of fiscal support would not differ from that of the public library. Before the concept of such resource centers is taken further, however, the participants of this conference are challenged to respond to the suggestion regarding the locus of responsibility for their creation and development.

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PATIENT/HEALTH EDUCATION--THE LIBRARIAN'S ROLE
A SELECTED BIBLIOGRAPHY

Compiled by
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Introduction

Increasingly lay persons are demanding, as a right, access to information about their own health, their doctors' diagnoses and prescriptions, and medical alternatives open to them. The whole consumer movement, with its accent on open access to information of all kinds, as well as the widespread concern with health care and costs, have strengthened the emphasis upon patient/health education as a citizen's right.

This right to health information includes not only the right of the patient to information about his condition and treatment but also the right of well persons to accurate health information before they consult a physician. Included, also, is the right to information by the families of patients unable to receive it themselves.

Recognition of the concern of the public for health related information is reflected in a similar concern and awareness among health personnel, and the recognition that delivery of health education must involve the cooperation of many disciplines. Mechanisms for supplying the information and its interpretations have not, however, kept pace with either the awareness or the need. The literature is both sparse and scattered. The interdisciplinary nature of the problem presents a complex bibliographical search process, frequently minimally rewarding.

Long before the current consumer movement, the general lay

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public was seeking information from public libraries or was turning to medical libraries oriented primarily to the supplying of information to the medical profession. In turn, librarians have been uneasy about providing health information, uncertain about the reliability of the materials which could be acquired, unsure of the ability of many lay persons to utilize scientific material, but aware that their clients frequently had nowhere else to turn and therefore reluctant to refuse access to such materials as were available.

Librarians, whether medical or public, have never contributed as they might to the monumental task of supplying health education, notwithstanding the fact that the heart of the profession of librarianship lies in the selection, acquisition, organization, storage and retrieval of information of all kinds. Public librarians have been hampered by insufficient medical background and little or no contact with the diagnostic and therapeutic team - physicians, nurses, and other highly trained health personnel. Medical librarians, until recently, have considered their role to be confined to direct service to the health personnel. Even within this latter role research has shown that the hospital library is frequently seen by the rest of the health team as operating on the fringe of the health system. The response of the librarians to a situation of such ambivalence must of necessity be an effort to define, and then to constitute, a role which will clarify the library's contribution to the need for more effective provision of health information to the patient and to the lay consumer.

It is to this total situation that the selected bibliography which follows is addressed. An effort has been made to approach this holistically, to analyze major component parts of the question of patient/health information, and to provide access to representative literature which has been generated relevant to the subject. By the very nature of the literature and its citations, an increasing span of other materials will then be exposed and can be explored, judged for usefulness in relation to particular situations, and projected into the future.

The bibliography has been presented under eight over-ride headings:

Patients' Rights/Consumer Protection

Statements by organizations and individuals as to what is perceived to be the rights of patient/consumers

Professional/Patient Communication

The dialogue among health care professionals concerning current practice or future directions in communication

with the recipients of health care

The Librarian's Role

The librarian's self-perception of the role of the library in meeting the mandate for health information

Service Modes and Planning

A sampling of the various responses available in the area of planning for new or expanded services

Cooperative Configurations

Citation of various types of joint ventures involving libraries, educational institutions, hospitals and others

Core Collections

An assemblage of book and/or journal lists and bibliographies to assist librarians in selecting, budgeting, and acquiring materials

Bibliographic Control

A miscellany of control aids to suit the various types of collections and media represented in health care facilities

Other Sources

A collection of information about other media sources e.g. data bases, pamphlets, booklets, advertising and handout materials and telephone (tape recording) services

Inclusions have been selected to represent the variety of articles found. Index Medicus was searched and articles selected, 1976 through September 1978, with a supplement through mid-January, 1979. In the search the MeSH headings found to be most productive were:

community medicine/ health services	libraries
consumer satisfaction	libraries, hospital
health education	libraries, medical
health services	libraries services
information services	patient acceptance of health care
	patient compliance

Other headings showing fair retrieval potential were:

community health aids	health welfare and planning
comprehensive health care	health facilities
consumer organizations	information science
delivery of health care	library technical services

The subject heading, information services, yielded a wealth of titles devoted to specific health or disease education topics e.g. aging, alcohol, arthritis, cancer, drug abuse, family planning, nutrition etc. This entry demonstrated a high capability for retrieval if very specific subject material about health problems were needed.

Library Literature and Library and Information Science Abstracts were searched from 1976 through 1978. In general these indexing services were much less rewarding in the material retrieved than was Index Medicus. Subject headings which proved useful were:

consumer/s	librarianship
cooperation (library)	libraries/libraries, hospital, medical
health/health services	periodicals, medical

Although not cited specifically, attention needs to be drawn to the Public Health Reports of the United States Public Health Service, and to the Health Education Monographs of the Society for Public Health Education, Inc. Both publications are rich sources of the thoughts, methodology, programs, and materials of the traditional lay public health educators.

To reiterate, the effort has been to sample selectively and to lead into the literature in such a way that a nucleus would be generated capable of expanding in multiple directions. Used in this manner the bibliography should prove both extensible and flexible. The literature on patient health education is not prolific. Too little has been reported and many areas have been almost disregarded. It may well be that this fact is one of the most compulsive reasons for instituting a more concerted effort to both generate and to delineate a professional role for librarians in the lay health information area.

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Goldie, Ray R. "The Requirements of Informed Consent." Hospitals 46 (May 1972): 58-61, and 126.

Medical procedure, surgery, or treatment involves touching the patient's person. Patient's consent is the authority to do so, while protecting the physician from a battery charge. Judicial decisions are also defining negligence by physicians. Bibliography (16).

Jemison, Karen. "Informing Patients." Library Journal 103, 1 May 1978, p. 909.

Letter to the Editor in reply to Berry. A brief array of views on providing health information to the public. "If 'a little knowledge is a dangerous thing', is ignorance better?"

Laforet, Eugene G. "The Fiction of Informed Consent." Journal of the American Medical Association 235, 12 April 1976, pp. 1579-85.

Surgeon challenges idea that patient can consent on basis of being "informed". Feels medicine should be treated as other fields, i.e. "caveat emptor". Full disclosure can create conflict in therapy and erode patient confidence in the physician. Bibliography (21).

Lazes, Peter M. "Health Education Project Guides Outpatients to Active Self-Care." Hospitals 51, 16 February 1977, pp. 81-6.

Description of the outpatient educational program designed to "equip outpatients to assume their share of staff-patient relationship". Group discussions and workshops are used in preventive, high-risk, and specific health problem programs.

Massey, Robert U. "Education for Change: The Next 25 Years." Connecticut Medicine 40 (October 1976): 713-17.

Author sees role of the physician remaining as teacher. Forecasts by medical school deans are given. He feels that, throughout the educational process, human biology should be taught so that the physician needs only to augment or correct what his patient has learned. Bibliography (6).

Parkin, D.M. "Survey of the Success of Communications between Hospital Staff and Patients." Public Health (London) 90 (1976): 203-09.

"A survey of discharged hospital patients sought their opinions on the adequacy of the information which they had received during their stay." Half or less understood the nature of their illness, treatment, or drug therapy. Bibliography (16).

Rosenberg, Stanley, and Judkins, Beatrice A. "Federal Programs Make Education an Integral Part of Patient Care." Hospitals 50, 1 May 1976, pp. 62-5.

A description and comparison of programs in Long-Term Care facilities and those given through the Dept. of Agriculture's

Cooperation Extension Service.

Silverman, Mark E., and Lamitina, Donnah. "Improved Patient Care Through Patient Education." Journal of the Medical Association of Georgia 65 (April 1976): 111-13.
A health education center developed a program to provide service to individuals, patient families, staff and the community. Outreach detection and prevention programs are also offered. Service is subject to an evaluation. Bibliography (2).

Walton, Charles W. "Informing Patients." Library Journal 103, 1 May 1978, p. 909.
Letter to the Editor in reply to Berry. Offers an exception to rule of restrained service by some hospital libraries in service given by Veterans Administration hospitals. Enthusiastic support of chief librarian is responsible for expansion of services.

Welbert, Robert T., and Doe, Donald A. "Experience in an Organized Patient Education Program." Journal of the American Pharmaceutical Association 16 (August 1976): 450-52.
Pharmacists see education as a means of reducing patient non-compliance with therapeutic regimens. Physicians and pharmacists cooperated in creating, reviewing, and providing instructional materials to clients.

The Librarian's Role

American Library Association. Health and Rehabilitative Services Division. "Special Issue: Health Education." Health and Rehabilitative Library Services 1 (March 1975): 3-12.
Public movement for health education as a consumer right raised questions of role of libraries and how they relate. Historical attitudes and assumptions lead to current self-perception of librarians. Advantages of success are summarized. List of concerned agencies is given. Bibliography (89).

Collen, F. Bobbie, and Soghikian, Krikor. "A Health Education Library for Patients." Health Service Reports 89 (May/June 1974): 236-43.
A description of the development and services of the Kaiser-Permanente Medical Care Program, which is a predominantly non-print collection. The discussion offers insights into the process of creating such information services.

Conaway, M. Christine. "Patient/Family Education: Reaching Out to Wellness." Catholic Library World (March 1977): 328-31.
The hospital librarian has a special role in well organized programs of education which can motivate the patient and family to be active in self-care.

Cummings, Martin M. "Your National Library of Medicine." Journal of the American Medical Association 233, 29 September 1975, pp. 1359-61.

Detailed description of the range of services of NLM for hospitals, medical schools, or other health science libraries. Lists location of the 11 Regional Libraries. Article written by a physician for his colleagues.

Davies, Nicholas E. "The Future of Small Hospital Libraries." Journal of the Medical Association of Georgia 66 (September 1977): 681-84.

Description of the Southeastern Regional Medical Library Program. An appeal to physicians, administrators, and trustees to see the use of such programs as critically important to small, rural hospitals for both staff and patient education.

Ellsworth, Susan Marsh. "Crisis Center Librarian: You Gotta Be Weird ..." Top of the News 32 (November 1975): 67-72.

If a full-scale information center cannot be afforded, a volunteer Information & Referral health information Hotline may suffice. The contributions a librarian can make are discussed. Training is emphasized. An examination of librarian attitudes is made. Bibliography (7).

Gold, Robert A.; Fink, Wendy Ratcliff; Stearns, Norman S.; and Bloomquist, Francis A. "The Health Information Specialist: A New Resource for Hospital Library Services and Education Programs." Bulletin of the Medical Library Association 62 (July 1974): 266-72.

A program for community hospital librarians for: improving effectiveness; assisting hospital educators; and facilitating coordination of resources and services. Stresses inclusion of orientation program for administrators and educators. Bibliography (14).

Harris, Cheryl. "Hospital-based Patient Education Programs and the Role of the Hospital Librarian." Bulletin of the Medical Library Association 66 (April 1978): 210-17.

Librarians uniquely trained to provide health education information; in assembling, cataloging and managing collections of materials; and in providing documentation of use. Expertise should be contributed to patient care, education, and research. Includes annotated Guide to Materials (15) and References (38).

Holtum, Edward A.; McKloskey, Judith; and Mahan, Ruth. "Coordinators for Health Science Libraries in the Midwest Health Science Library Network." Bulletin of the Medical Library Association 65 (April 1977): 224-30.

Examination and evaluation of the role of coordinators in network planning. They have proven their value in consortium formation, basic unit development, communication facilitation and program initiation. Tables of component bodies and coordinator activities included. References (9).

Koughan, William P. "Hospital Library Standards-An Administrator's View." Special Libraries 66 (December 1975): 588-91.

An administrator suggests that librarians bring all library

services to the attention of administrators, and assist in the development of library inspection guidelines for accreditation of hospitals. Bibliography (5).

Marshall, Joanne Gard, and Hamilton, John D. "The Clinical Librarian and the Patient: Report of a Project at McMaster University Medical Center." Bulletin of the Medical Library Association 66 (October 1978): 420-25.
Clinical librarian's role is to assist patients to participate in their health care, and health professionals in the application of latest literature. Benefits include: accessibility of information to patients; health professional's awareness of the library and literature; and an opportunity for librarian to view activities and needs of clinical setting. References (9).

Mathes, C. B. "Education as Health Care." Library Journal 103, 1 May 1978, p. 909.
Letter to the Editor in reply to Berry. Head of VA hospital debunks arguments for limiting patient access to information. He feels disclosure is essential to preventive medicine.

Robertson, William O. "Medical Library Services-Innovations in Washington." The Western Journal of Medicine 124 (April 1976): 344-45.
A physician addresses his colleagues on the concept of shared resources. Description of the Pacific/Northwest and Washington/Alaska Regional Medical Library Programs.

Swezey, Annette M., and Kaufman, Anita. "Library Cart Service Provides Information for Clinic Patients." Hospitals 51, 1 September 1977, pp. 65-7.
Description of the patient education library at L.A. County/Southern California Medical Center. Librarian and volunteers help patients select relevant materials for themselves and their families for coping with illness.

Truelson, Stanley D., Jr. "Selecting for Health Sciences Library Collections When Budgets Falter." Bulletin of the Medical Library Association 64 (April 1976): 187-95.
Excellent case made for exploiting expertise of librarian for selectivity necessary to develop source collection on a limited budget. Detailed analysis of various media. Alternatives of shared acquisition and network access are discussed. Bibliography (39).

Wallace, Glenn. "Health Information to Patients--The Role of the Hospital Library." Show-Me Libraries 29 (May 1978): 3-5.
Discussion of the attitudes of patients and health care professionals toward a Patients' Library/Health Information Center. Development of community and public library contacts is suggested. Bibliography (4).

Wender, Ruth W. "Hospital Library Standards." Special Libraries 67

(July 1976): 6A-7A.
Letter to the Editor in reply to Koughan. Authoritative restatement of Standards, as submitted by Medical Library Association, for inclusion in Inspection Manual of Joint Commission on Accreditation of Hospitals.

West, Kelly M. "Library and Information Services for Small Hospitals." Journal of the American Medical Association 232, 5 May 1975, pp. 505-08.
Primitive or no service exists for more than half of U.S. hospitals. Costs led to mini-budget programs of Regional Medical Libraries, with supportive consultant, reference and photocopy services. Stresses distinction to be made between need for library and need for information. Cooperation is the solution. Bibliography (41).

Service Modes and Planning

Albright, John B. "A Bibliography of Community Analyses for Libraries." Library Trends (January 1976): 619-41.
Service requires a planning which involves some form of analysis of needs. An annotated review of a variety of such surveys. Unique common element is that each is based on entire community i.e. users and non-users, with subject areas crossing disciplines and user populations. Annotated Bibliography (87).

Bovay, Sue. "Community Information Service in the Monroe County Library System: A Model." Drexel Library Quarterly 12 (January/April 1976): 93-109.
Analysis of countrywide service to 36 libraries and the creation of a Human Services Directory of 325 programs. The role perception of librarians and social workers is explored. The process of securing funding, and detailed cost analyses are included.

_____. "Information and Referral Services." California Librarian 37 (July 1976).
An invaluable state-of-the-art report on the subject to which the entire issue is devoted.

Childers, Thomas. "The Neighborhood Information Center Project." The Library Quarterly 46 (1976): 271-89.
Excellent definition of I & R service and resources at five libraries. Although health information is not specified, the attitude, approach and method useful in innovating and/or expanding services are worthy of use as a guide. A good case is made for the role of the librarian in the cooperative venture. Bibliography (17).

Costa, Robert N. "Project Tips, or How to Establish a Community I & R Service." Pennsylvania Library Association Bulletin 22 (Summer 1977): 104-06.

A countrywide I & R service to 22 libraries in a rural setting. Securing funding and identity was followed by development of resource files. Publicity established service. Example of a modest approach to meet the needs of an unique region or area. Author offers materials assistance to other similiar libraries.

_____. "Information Centers-Theory; Practice; Issues and Trends; and Educating the Information Specialist." Drexel Library Quarterly 12 (January/April 1976).

Excellent reports of various phases of the Monroe County project and related topics, to which this entire issue is devoted.

Huang, C. K. "The Delivery of Information Services in a Health Sciences Library." Bookmark 37 (Spring 1977): 58-63.

The role of the computer and information services is discussed. Standards of service among various organizations are compared. Present and future policy of fees for bibliographic services is offered. Bibliography (7).

Jeuell, Carol Ann; Francisco, Cecilia B.; and Port, Jane S. "Brief Survey of Public Information Services at Privately-Supported Medical School Libraries: Comparison with Publicly-Supported Medical School Libraries." Bulletin of the Medical Library Association 65 (April 1977): 292-95.

Survey of 44 libraries to determine policy on scope of services and clientele. Questionnaire included. Bibliography (1).

_____; Francisco, Cecilia B.; and Port, Jane S. "Public Information Services at State-Supported Medical School Libraries: A Brief Survey." Bulletin of the Medical Library Association 64 (October 1976): 415-17.

Survey of 57 libraries indicated only marginal service to the general public. Description of New Jersey Health Sciences Library. Questionnaire included.

Paulson, Mandy, and Sheppard, Judy. "Information and Referral: A Selected Bibliography." California Librarian 37 (July 1976): 34-42.

Definitions of information service in many areas of human social services are included in this review. Parameters of service may be assessed by the librarian through this survey guide. Extensive bibliography (203).

Salber, Eva J.; Beery, William L.; and Jackson, Ethel J.R. "The Role of the Health Facilitator in Community Health Education." Journal of Community Health 2 (Fall 1976): 5-20.

Duke University's Dept. of Community Health Services has initiated a program which trains unpaid lay people as "health facilitators". Current literature is reviewed. A detailed description of staffing and development of the program follow. The Appendices list Problems and Topics submitted by clients.

Similiar to I & R services. References (29).

Cooperative Configurations

Casey, Genevieve M. "Alumni Update Bibliography-Multitype Library Cooperation." (Presented at Wayne State University-Division of Library Science Alumni Update Conference, 6 May 1978).

Bibliography (16) dealing with library cooperation, national library systems and networks.

_____. "Grants." College & Research Libraries News 38 (April 1977): 95.

Announcement of 2-year grant from NLM to Syracuse University to develop Health Information Sharing Project (HISP), and to "examine and develop ways of facilitating the flow of health information in a community".

Goodchild, Eleanor. "CHIPS-Consumer Health Information Program and Services-in Los Angeles." California Librarian 29 (January 1978): 19-24.

Medical and regional public library cooperation required new approaches and objectives. Combined program planning included definitions of mutual problems, goals. Brief history of a successful venture.

_____. "The CHIPS Project: A Health Information Network to Serve the Consumer." Bulletin of the Medical Library Association 66 (4) (October 1978): 432-36.

Report of a project having as its goal the formation of a health information network to serve the consumer, the public library client, and the hospital patient. The project's objectives are discussed and an active role for all libraries in the consumer health education movement is encouraged. References (14).

Goronzy, Daniel W. "Area Health Education Center: A Model of a Consortium Approach to Health Manpower Education and Consumer Education in Southeast Tennessee." Journal of the Tennessee Medical Association 68 (November 1975): 883-86.

SETAHEC is a consortium of hospitals, educational institutions, and health planning agencies and involves thirteen counties. It is designed to meet continuing education of health care professionals and consumer education, despite rising costs and manpower shortages in those areas.

_____. "Massachusetts Health Info Network Launched by Public Libraries." Library Journal 102, 15 December 1977, p. 2464.

Announcement of Community Health Information Network (CHIN) composed of six metropolitan public and one hospital library. Formed for interlibrary loans, collection development, and reference staff in-service training.

Vokes, Robert W. H. "Community Information and Referral Services: The

Cleveland Experience." Catholic Library World (March 1977): 334-37.

The I & R service of a Neighborhood Information Center is defined as directional rather than diagnostic. Stress is laid on staff training, publicity, support by the administration, and a commitment to fulfilling a basic need. References (6).

Core Collections

Allyn, Richard. "A Library for Internists." Annals of Internal Medicine 84 (March 1976): 346-73.

Revised list of 334 texts and 140 journals which are grouped by areas: general internal medicine; sub-specialties; basic sciences and clinical disciplines related to internal medicine. Prices included and books and journals are listed separately. Based on survey of practicing specialists. References (5).

Beatty, William K., and Beatty, Virginia L. "A Medical Collection." American Libraries 5 (May 1974): 250-53.

Suggested collection for community service in public libraries. Discussion of selected items, with the lay reader in mind. 64 items listed.

Brandon, Alfred N. "Selected List of Books and Journals for the Small Medical Library." Bulletin of the Medical Library Association 64 (April 1977): 191-215. 7th revision.

Subject/author index of 472 books and 138 journals with prices included. Discussion of selected items. References (12).

Bunting, Alison; Mirsky, Phyllis S., Yokote, Gail; and Furman, Judith A. "Selected List of Medical Reference Works for Public Libraries." (Bibliography presented at San Diego Health Information Networkers Conference, 21 April 1977).

42 books listed with annotations, grouped by types e.g. dictionaries, handbooks, etc. A second list offers 98 sources of consumer educational materials. Based on Maina/French list (below).

Caruso, Judith, and O'Sullivan, Pauline. "To Your Good Health!" Unabashed Librarian 75 (Fall 1975): 19-21.

Annotated list of 63 books, grouped by topic, for lay reader in the public library.

Farnham, Sarah. "A Suggested Medical Collection for the Medium-sized Public Library: An Annotated Bibliography." (Presented at the Michigan Library Association Meeting, Fall 1978).

Annotated list of 43 books, grouped by type, with prices included. Bibliography (6).

Maina, William, and French, Beverlee. "Medical Reference Works for the Public Library." News Notes of California Libraries 70 (1975):

24-32.
Discussion of the core collection needs of a public library. Lengthy annotations of 30 books. Bibliography (3).

Nowak, Geraldine D., for National Library of Medicine. "Patient Education-January 1973 through July 1975." Index Medicus: Bibliography of Medical Reviews. Search 75-7.
Compilation of 263 citations, in English, including the MeSH headings.

Onsager, Lawrence W. "A Bibliography of Recommended Lists of Books and Journals for Health Science Libraries." Bulletin of the Medical Library Association 66 (July 1978): 338-39.
19 annotated citations which cross several health care professions and settings.

Raskin, Robert B., and Hathorn, Isabel V. "Selected List of Books and Journals for a Small Dental Library." Bulletin of the Medical Library Association 64 (July 1976): 265-71.
Discussion of needs, followed by list of 109 books and 20 journals concentrated on dentistry. Suggested for use in a small health science library. Prices included.

Veterans Administration Hospital Library Service. Roth, Britain G. et al. "Patient Health Science Education: A Bibliography, with Abstracts." (Bibliography presented at Graduate Library School Students Practicum, V.A. Hospital Library, Buffalo, N.Y., 19 July 1976).
45 titles drawn from MEDLINE, in English, covering 1974 to mid-1976. Grouped by: Approaches and Needs (12); Specific Problems (illnesses) (27); and Methods (media) (6). Lengthy abstracts.

Walker, William D., and Hirschfeld, Lorraine. "Sources of Health Information for Public Libraries." Illinois Libraries 58 (June 1976): 459-502.
Comprehensive annotated reference and selection aid, with several hundred titles including prices. Grouped by subject area and encompassing both print and non-print media.

Bibliographic Control

Bess, Elvin D., and Divett, Robert T. "A Core Textbook Collection in a Health Sciences Library." Bulletin of the Medical Library Association 65 (April 1977): 287-89.
Cataloging techniques for core collection of biomedical textbooks. Table of 41 subject headings. Discussion of book selection and circulation policies. Bibliography (4).

Lyon-Hartmann, Becky, and Goldstein, Charles M. "Recommended Data Elements for the Descriptive Cataloging of Computer-based

Educational Materials in the Health Sciences." Library Resources and Technical Services 22 (Spring 1978): 191-95.
NLM's National Center for Biomedical Communications (Lister Hill) recognized a need for this control. In addition to the elements, a review of four indexes available is included. References (1).

Sheppard, Judy, and Scheffler, Diana. "Subject Headings for Information and Referral." California Librarian 37 (July 1976): 14-17.
Subject headings suited to I & R are given, including some for health care information. Contrasts with Library of Congress and other schemes are made.

Wegener, Judith E. "Developing a Computerized Organizational File." Library Journal, 15 November 1977, pp. 2323-25.
Monroe County's Organization Directory contains 850 organizations. The evolution of the 95 subject headings is described. Programming design and future developments are discussed.

Other Sources

Poucher, Christine. "New and Unusual Reference Sources." Southeastern Librarian 28 (Spring 1978): 31-4.
To meet patron needs, imagination in locating and acquiring sources may be required. Examples of methods are offered as a guide.

Tabakin, Rhea. "Health Education Materials and the Organizations Which Offer Them." New York Health Insurance Institute n.d.
Pamphlet containing an alphabetical list of organizations with addresses and types of materials provided. Free items are noted. 146 entries.

Van Vechten, Doris; Satterwhite, Betty; and Pless, Barry. "Health Education Literature for Parents of Physically Handicapped Children, An Update." American Journal of Disabled Children 131 (March 1977): 311-15.
First revision of the literature which is reviewed. List of 99 items with description, price and audience served i.e. parent, child, etc. Addresses also provided. References (29).

Williams, Martha E., and Dunatov, Elaine Tisch. "Data Bases for Coping With Human Needs." Drexel Library Quarterly 12 (January/April 1976): 110-38.
Data bases used by neighborhood information centers and I & R services. Grouped by: Machine-readable data bases (55); I & R Service Center files (30); and a section on Major Information Sources and Bibliography (215). Discussion precedes each group.

_____. "The Impact of Machine-Readable Data Bases for Library and Information Services." Information Processing & Management 13

(1977): 95-107.

Exploration of origins, growth, technological development and current and future activities of data bases in meeting objective of making easily accessible information to those who need it. An examination of the program proposed by the National Commission on Libraries and Information Science reveals need for networking and shared resources.

Special Items: Telephone Services

Communications in Learning, Inc. "CAN-DIAL" (Descriptive materials available from their offices at 2929 Main Street, Buffalo, N.Y. 14214).

The Can-Dial Public Health Education System is a non-profit educational medium, devoted to the subject of cancer, including news on research and treatment techniques. Developed by Roswell Park Memorial Institute and the National Cancer Institute.

Barlett, Marjorie H., and Meyer, Thomas C. "Patients Receive Current, Concise Health Information by Telephone." Hospitals 50, 16 February 1976, pp. 79-82.

University of Wisconsin's library of 4-minute tapes under 36 titles plus 450 individual messages, including 22 in Spanish, called HEALTH-LINE. Bibliography (3).

_____. "MED-HELP at Memphis-Shelby." Library Journal 101, 15 June 1976, p. 1373.

_____. "Tennessee." Southeastern Librarian 26 (Summer 1976): 109.

Description of public service of a 24-hour I & R listening service on more than 40 topics, its acronym meaning Medical Health Listening Program. Sponsored by combination of a county public library, medical society, and University of Tennessee medical school.

_____. "Health Info Access in Ohio & Maryland." Library Journal 102 (August 1977): 1551.

Announcement of inauguration of MED-LINE, an I & R service, developed for the San Bernadino Medical Society, which was to be capable of offering 300 tapes and handling as many as ten simultaneous phone calls. Joint venture of Public Library of Columbus and Franklin County.

Additional announcement of similiar service, TEL-MED, the creation of the Prince George's County's Medical, and Dental Society. A library of 250 tapes available to clients who are solicited by the distribution of pamphlets throughout the county. Brochure available from Prince George's General Hospital & Medical Center, Cheverly, MD 20785.

*Prepared for an institute, Patient/Health Education: The Librarian's Role, sponsored by the United States Office of Education under The Higher Education Act II B, Grant G007800601, February 5-9, 1979.

MEDLINE UPDATE

January 1977-January 19, 1979

Elsesser, Lionelle. "Health Information for Patients." Bulletin of the Medical Library Association 66 (July 1978): 362-63.

A letter to the Editor in reply to Roth's article (see below) in which attention is drawn to additional sources of resources: the Bureau of Health Education and the National Center for Health Education. She describes the exclusion of librarians at the planning stage of patient education committees in hospitals. She questions using the MeSH terms for the catalog and closes with comments of the availability of staff and time to service TEL-MED and resource lists (Core Communications in Health).

Lima, Daryl. "Stop the Presses--Another Critique." Hospitals 52, 16 September 1978, p. 16.

A letter to the Editor in reply to Mundt's article (see below) opposing the view that consortia are means of expanding interlibrary loan privileges. Conversely, statement of their value as clearinghouses is made.

Matheson, Nina W. "The Clouded Crystal Ball and the Library Profession." Bulletin of the Medical Library Association 65 (January 1977): 1-5.

Discussion of Library trends: change in management practices; moving emphasis on technical processing to client-oriented outreach services; identifying education as primary professional role of librarian. Bibliography (15).

Mundt, Jeannie L. "Hospital Libraries' Consortium Blunts Impact of Budget Cuts." Hospitals 52, 1 June 1978, pp. 75-78.

Faced with increasing costs and decreasing budgets, several medical and hospital libraries in Illinois have formed a consortium emphasizing shared resources, interlibrary loans, librarian consultation services and cost-saving projects.

_____. "The Information Needs of the Prescribing Physician." (Papers presented at a Symposium held by Association of Information Officers in the Pharmaceutical Industry, London (England), 20 October 1976). Postgraduate Medical Journal 53 (September 1977): 543-67.

First two papers describe information needs of general practitioners and hospital doctors. The remainder reveal the array of information resources available within the hospital setting, including those of the library. Enterprising and cost-conscious librarians would do well to become aware of materials that may be near at hand.

Raper, James E., Jr. "Centralized Automated Cataloging of Health Science Materials in the MLC/SUNY/OCLC Shared Cataloging Service."

Bulletin of Medical Library Association 65 (April 1977): 231-36.
A health science library selecting a network as a means of meeting its increased service needs will next need to address the technical services required in bibliographic control. SUNY-OCLC offers a subscription service to satisfy that need. A discussion of its development, implementation, operation, and budgeting is offered. Bibliography (11).

Roth, Britain G. "Health Information for Patients: The Hospital Library's Role." Bulletin of the Medical Library Association 66 (January 1978): 14-18.
Author contends that hospital libraries have a new role to fulfill in providing patient health education. In addition to its services to staff, it should function as the center for educational materials and programs. Guidelines are suggested for establishing such a center. References (15) Appendix I (Bibliography) 14.

Tumulty, Phillip A. "The Art of Healing." The Johns Hopkins Medical Journal 143 (October 1978): 140-43.
This commencement address stresses the importance of adequate communication between the professional (i.e. physician) and the client (patient). An excellent summary of the goals, needs, and human interaction required in dealing with those seeking health information.

Van Gieson, William R. "The Hospital Library in Transition." Hospital Progress 59 (June 1978): 66-69.
The community hospital library has achieved a new status due to advances in medicine and technology, rising consumer expectations to be "well", health care specialization, legislation, and malpractice and/or licensure concern. Suggestions are offered to help the library and librarian to function in this broadened range of roles from reservoir of information to public relations resource.

LEGAL DIMENSIONS OF LIBRARY SERVICE

Ralph Slovenko

Though the reported cases apparently are singularly free of any litigation against librarians in providing services, there is growing concern about their responsibility. The invitation to speak on the subject, I would assume, is indicative of that concern. There are persistent rumors about litigation involving librarians, and there appears to be pervasive apprehension among librarians. Librarians are scared. At a recent meeting of the New York Regional Group of the Medical Library Association, many librarians claimed that providing information could place them in jeopardy of being prosecuted for practicing without a license or sued for malpractice.[1]

In the United States about a century ago, the library took on the responsibility of providing personal assistance to its users. Traditionally, the role of the librarian is that of custodian, collector, and cataloger, but in the United States and a few other places, the librarian has also undertaken to furnish personal assistance on an organized basis. Rothstein points out that this was not just happenstance. We have reference service, he notes, because it was once a cause that was strongly propagandized for and brought to fruition.[2] Of course, there were many instances of personal helpfulness by librarians, but these were made as a matter of courtesy rather than as a matter of practice.

The assumption of aid, as every lawyer knows, has legal consequences. In general, the law imposes no duty to come to the assistance of a person, whatever his difficulty or peril, but assistance of a person, whatever his difficulty or peril, but when an individual does undertake to aid another, he is regarded as entering voluntarily into a relationship which is attended with responsibility. He is now a person burdened with a duty of care. Thus one who, without any legal obligations to do so,

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attempts to remove ice from the sidewalk, may find himself liable when he makes the situation worse.[3]

What are the bounds of personal assistance given library patrons? In an article entitled, "Dracula in the Stacks," Sonnichsen describes some library users as "vampires." There are the individuals who make such demands on the librarian, Sonnichsen writes, that they leave him (or her)[4] feeling exhausted, as though all of his blood had been sucked out. They come not only by foot, they come by letter and telephone, and they make such requests: "Please list and analyze Kierkegaard's writings, and give me quotes reflecting aspects of existentialist thought."[5]

The example points up the distinction between a request for information--i.e., the titles of Kierkegaard's writings--and a request for something more, in this case, an analysis. Thus, a request made of a law librarian for an interpretation of a statute would go beyond the giving of information and would constitute the giving of advice, or unlawful practice. There are times, however, when the line is not easy to draw between providing information and practicing without a license. How does one determine whether it is information or advice that is being elicited? Quite often, actually, the problem is trying to figure out just what is the question? That too, we all know, perplexed Gertrude Stein. Librarians say it is often difficult to get the patron to formulate the reference question in a good enough way. When the question is vague or rambling, the librarian may actually be providing advice in trying to sift through to a question.[6]

Suggestions have been made that the practical techniques used in counseling may be applied to reference interviews, and as a consequence, the application of the law on counseling to the librarian. Peck in Reference Quarterly points out that both counseling and librarianship are "helping professions" and their goals are similiar in assisting people in finding answers to individual needs. The counselor provides help with emotional and personal problems; the reference librarian acts as a guide in finding information. The major difference between the two types of services is the length of time involved in each--the counseling sessions may last weeks whereas the reference interview is usually brief.[7]

According to reference librarians and information specialists, we may note, there are five filters through which a question passes, and from which the librarian selects significant data to aid him in his search. They are: determination of subject; objective and motivation; personal characteristics of inquirer; relationship of inquiry description to file organization; and anticipated or acceptable answers.[8] Taylor, writing in College and Research Libraries, says that when

trying to determine whether the patron's question requires information or advice, "you have to have this suspicion--a sensing of when it is you know what it is the inquirer wants, and when it is you are sure he has got it clear, and when it is you are not sure."[9]

The aim of the librarian thus is to serve as a guide to information, and not to be a vehicle interpreting the information. The information thus is to pass unfiltered by the librarian's understanding of the information for himself. The librarian thus becomes something of a translator, interpreting and restructuring the inquiry so it fits the files as they are organized in the library.[10] So, while it may be within the role and responsibility of the reference librarian as an information provider to interpret the question, it is not deemed proper to interpret the answer or information sought.

Taylor in his article in College and Research Libraries points out that the librarian should be concerned with what kind of answer is useful or acceptable to the inquirer.[11] Questions in the area of law, for example, may be very precise, but the answers are less precise. Taylor writes: "One of the nagging problems in the delivery of answers seems to be that the degree of evaluation the information staff can and should make."[12] The phrase that Taylor and others use is, "information staff," not "interpretation or evaluation staff."

In the following, consider whether the librarian takes an information request and supplies an opinion or advice:

> Inquirer: Can you give me some information on the treatment of cancer?
>
> Reference Librarian: Here's a book on laetrile.

Another illustration:

> Inquirer: Can you give me some information on diet pills?
>
> Reference Librarian: I think you had better see a doctor about that.

Still another illustration:

> Inquirer: I'd like to know something about color television.
>
> Reference Librarian: Do you want books or information?

In the third example, the librarian uses the "open question" interview technique, that is, a question is open when the

response is left up to the respondent, or as sometimes put, when the question cannot be answered "yes" or "no".[13]

What if the librarian suggests a book that recommends a product, or otherwise gives information about a product or procedure, and a serious injury results? Could the patron successfully bring a suit of negligence against the librarian, as well as the manufacturer of the product? What are the legal implications, if any, of librarianship?

In general, for liability in tort, it is necessary to establish negligence, or breach of a duty of care owed to the complainant, and a casual nexus between that negligence and the alleged injury. Whether or not there is negligence or fault based on advice--for example, to recommend trying a product, or to say that twelve months remain in which to file suit or else it will be barred by the statute of limitation--depends upon the relationship of the parties. Given the relationship, is the act done or advice given consistent with the exercise of ordinary care under the circumstances? Negligence involves an element of duty; it is the failure to exercise that degree of care which a person of ordinary prudence would exercise under similiar circumstances. Negligent conduct may involve either (a) an act which the actor as a reasonable man should recognize as involving an unreasonable risk of causing an invasion of legally protected interest of another, or (b) a failure to do an act which is necessary for the protection or assistance of another and in which the actor is under a duty to perform.[14]

Is a librarian subject to suit for "reference malpractice"? Or can it be said that a librarian is in law not like a counselor but like an educator, who owes (at the present time) no legal duty of care to students to support a negligent action for "educational malpractice." A student may not recover damages in tort alleging that, after graduation, he was unable to read and write simple basic English and no understanding of the other subjects covered in his courses.[15] So, just as an educator owes no legal duty of care to students, it may be said that a reference librarian, in either the public or private sector, owes no legal duty of care to patrons. At least, that is the apparent posture now of the law, but certain circumstances may present changes.

The information versus advice distinction, though a slippery one, is deemed crucial in the assessment of any duty undertaken. Thus, providing statutes and other legal material is one matter, whereas providing statutes, regulations, or reported decisions and citing them as authority, or interpreting them to achieve a particular result, is another matter. When one does not pay a fee for assistance, as one pays an attorney, it may be argued that there ought not be reliance

on the assistance. To be sure, the fee warrants a guarantee, but the good samaritan, without fee, is held responsible when he renders aid in a reckless manner. One who acts as a good samaritan must do so cautiously, especially when he does not carry risk insurance. Heitz in an article, "Legal Information vs. Legal Advice" in Emergency Librarian suggests that the library should put patrons on notice that its services are limited and, he suggests, written or oral disclaimers.[16]

Is a disclaimer necessary? Assuming the librarian furnishes advice and not merely information, is the position of the librarian any different than that of a writer of an advice column in the daily newspaper? To borrow an apt expression: "Some people go to their doctor once a year. Some go every day, so to speak, by just looking in their daily newspaper."[17] The New York Times advertises: "Get medical advice on your doctor's day off--in Jane Brody's PERSONAL HEALTH column, in the Living Section."[18] Is a newspaper columnist, author or other person responsible for the advice given? Dr. Williard Gaylin notes in his new book, Feelings: Our Vital Signs, that the seemingly endless flow of how-to books "guide the perplexed and despairing to inner peace via conflicting and contradictory pathways." The phony formulas may result, he says, in divorce, frenetic job search or frantic therapy-shopping.

Dr. Robert Atkins, author of "Dr. Atkins' Diet Revolution," recently won a malpractice suit when a jury ruled that he was not liable for the plaintiff's heart disease. The 73-year-old complainant weighed 214 pounds when she actually visted him. She was hospitalized four times in the next three months for heart ailments which her attorney claimed were a result of Atkins' diet. It is unknown whether the complainant failed to established liability claiming reliance on the diet book without actually consulting the author.

Ann Landers, at a recent annual meeting of the Michigan Bar Association, was asked if she had ever been sued. She reported that in her 23 years of giving advice, she had not been, but she admitted once having a close call. This involved a woman who had written to her saying that she was tired of always being asked, "What do I do for a living?" Ann Landers advised her, "Say you're a hooker, that will stop it, they'll be so surprised." The woman followed the advice, was overheard and got arrested for soliciting! She suffered indignity, and now has a criminal record. Her complaint with Ann Landers almost reached the courts. Ann Landers as well as other advice columnists, more often than not, conclude with a suggestion that the inquirer see a psychiatrist. We do not know what good that may do.

In everyday life we are all giving and receiving all kinds of advice. When advice is given on a social occasion it can confidently be said that no duty of care will be held to exist,

but the law imposes a duty of care when there is a contractual or fiduciary relationship, as in a physician-patient or lawyer-client relationship. Logically, there is no essential reason for distinguishing an injury which is caused by reliance upon words from an injury which is caused by reliance upon the safety of medication. Indeed, there are cases in which the distinction between word and deed is for all practical purposes nonexistent. A doctor is as much liable for negligently injecting the drug itself. Foreseeability of harm is sufficient to establish a duty to speak with reasonable care.

Apart from the duty of care, there must be, as mentioned, a casual nexus between the breach of that duty and the alleged injury. Suppose a library patron is given a book on cold remedies and dies of pneumonia after allegedly relying on the information in the book. Suppose the library patron is given an outdated book, for example, one saying that Tourette's syndrome is due to psychological rather than to combined organic and psychological causes. Suppose a library patron says he has difficulty getting along with people, and he is given Dale Carnegie's "How to Win Friends and Influence People," and thereafter he goes psychotic. Suppose a library patron complaining about sex problems is given a self-help sex manual, and following the instructions, he falls out bed injuring himself. The illustrations are without limit.

A refusal to provide a book or to restrict its use would, of course, violate the constitutional rights to know,[19] but does the librarian have any obligation to sort the wheat from the chaff? Corcoran, a cartoonist in The New Yorker, suggests the following classification for the shelving of books: Poppycock, Rubbish, Humbug, Balderdash, Stuff and Nonsense, Hogwash.[20] Librarians, in effect, censor by the use they make of their budget in the purchase of books. They censor also, in effect, by classifications. Critics point out the marked trend of authors nowadays to blur fact with fiction; book publishers are dividing sharply on their responsibility to ferret out the truth for readers.[21] Consider the task of booksellers. Some books are clearly marked "novels"; others are not. Booksellers are relieved when, for among reasons, a book is a best-seller; these books are lumped in one section "best-sellers" without classification. Thus, booksellers have not needed (at least up to now) to face up to the question whether Alex Haley's saga of an American family, Roots, is biography, fiction or fairy tale, it being a best-seller. The answer to the question on the librarian's duty to classify depends on whether the librarian will be expected to be a "maven" (Yiddish for know-it-all).

It has been suggested that the librarian, mindful of the limitations of the library, might refer the patron to an appropriate agency for assistance. Dykstra writing in Emergency Librarian

says, "A library is not just a repository of written information, it is also a valuable source of information on the community and for the community it serves."[22] The regulations of the Wayne State University Law School Library set out the following:

1. The reference staff will not help solve legal problems other than giving instruction in the use and arrangement of legal materials. (This section also contains a brief list of community agencies and their phone numbers.)

2. Telephone reference involving ownership of material will be done. Reference that involves research will not be done over the telephone. Assistance will be given in person.

3. Reference personnel will not read anything over the telephone.

The patron who is involved in a lawsuit and is doing his own legal research is more apt than others to push the librarian beyond his legal and ethical limits in order to obtain needed information.[23] He is indeed the "Dracula in the stacks." On the unauthorized practice of law, the American Association of Law Libraries Proposed Code of Professional Responsibilities and Ethics states that the provision should be understood as "not to give legal advice or opinion or interpretation of statutes or court decisions. On the other hand, if requested, both text of the law and the court interpretation of it, either in statutes or codes, or the decisions of the courts should be made available for everyone."[24] Thus, what might be considered unauthorized practice is what also might constitute the basis for malpractice action.

Perhaps a useful analogy on the scope of unauthorized practice may be the sale of books or forms designed to enable the layman to achieve legal results without the assistance of an attorney. By definition, the practice of law is not limited to conducting litigation, but includes giving legal advice and counsel, rendering services that require the use of legal knowledge or skill, and preparing instruments and contracts by which legal rights are secured, whether or not the matter is pending in court.[25] In a Michigan case, Virginia Cramer and others were publishing and selling do-it-yourself divorce kits. The State Bar of Michigan sued, claiming these activities constituted practicing law without a license. The Michigan Supreme Court resolved the controversy by permitting the sale of the kits with general textual instructions but proscribed the giving of personal advice in conjunction with the kits.[26] A similar rule has been adopted in other states which have faced the problem.[27] So too, the legal reference librarian

who provides only information and not advice would not be considered practicing law without a license.

The status of a reference librarian in the medical setting is not clear at this time largely due to the new Michigan Public Health Code and the American Hospital Association's "Patient's Bill of Rights" which provides for a patient's "right to be informed." The Michigan Public Code, in part: "A patient or resident. . . is entitled to receive information concerning his or her continuing health needs and alternatives for meeting those needs. . ."[28] It further provides: "A patient or resident is entitled to the opportunity to participate in the planning of his or her medical treatment."[29] The American Hospital Association's "Patient's Bill of Rights" states, in part: "The patient has the right to obtain from his physician complete current information concerning his diagnosis, treatment, and prognosis in terms the patient can be reasonably expected to understand."[30] The prevailing attitude on the part of patients--"I'm entitled"--may be attributed to the general trend of rights in consumerism. In considerable measure, bibliotherapy or self-help manuals are important dimensions to health care, and to the right to be informed.

The 6,500 hospitals across the nation belonging to the American Hospital Association are now undertaking patient information programs with the objective of telling the patient all about his or her case. The new programs are as diverse as the patients they serve. At Methodist Hospital in Indianapolis, patients turn on their TV sets every morning to learn about tests and procedures they may encounter during their hospital stay. At an Arizona hospital, while waiting for their prescriptions to be filled, patients watch a film about proper use of the medication, possible reactions and what to do if they have a reaction.[31]

On continuity of care, the patient's education is important. The "Patient's Bill of Rights" of the American Hospital Association states, in part: "The patient has the right to expect reasonable continuity of care. . . . The patient has the right to expect that the hospital will provide a mechanism whereby he is informed by his physician or delegate of the physician of the patient's continuing health care requirements following discharge."[32]

Is the reference librarian at a public or private hospital expected to provide information (or is delegated the duty) so that the patient is "informed" about his or her care in the hospital as well as provide continuity of care through patient's education without risk of liability for "negligent reference"? As the law is evolving, these librarians may have a legal duty to patients to provide information, and out of that duty may stem actions for malpractice. At some hospitals, librarians

are being instructed that they should not interfere with the relationship between doctor and patient. At other hospitals the patient is required to present a note from his doctor before information is given. At still other hospitals, special patient shelves in the library are being established where medical books written for the layman can be found. The librarians are evaluating the materials but they speak of patient education as a team effort--doctor, nurse and librarian working together on decisions concerning the extent of a particular patient's right to information.

Medical reference librarians in public or teaching hospitals report that they have had to change their attitudes quickly. The librarian in the public setting tends to give full service even over the telephone whenever possible. They will read definitions and terms over the phone and provide certain drug information. Usually, they will refer to the source: "According to. . . ."

There are many private health agencies to which a librarian can refer a patron such as the Heart Association and Cancer Society. In this respect the medical librarian stands in the same position as the legal librarian. If they suspect the patron needs advice rather than information, they may refer the patron to an agency.

To sum up. Considering that nowadays family members sue each other, it may not be too long before the librarian too is cast as a party defendant in a lawsuit. Suing, we know, is now a popular pasttime. Should the librarian be cast as a party defendant in the courtroom, the information versus advice dichotomy may serve as the touchstone of liability. When push comes to shove, however, the distinction between information and advice loses sharpness. They are nodal points on a continuum-not separate, discrete entities. Thus, when a librarian hears a problem, and suggests a book, the implication may be that others are not applicable--is this information or advice? In any event, it may seem inconceivable, as it does to me, that a librarian would be entangled in litigation for either information or advice, but who even in the recent past would have predicted the present state of litigation and liability?

Actually, litigation is not to be taken as the measure of the breakdown of relationships. The aim in tort litigation, more often than not, is to reach the insurance company standing behind the named party. Just as a raw oyster may be nothing more than a carrier of horse radish, so too a librarian, like others, will be asked to carry insurance so as to spread the loss of those suffering injury. Litigation and insurance, albeit in a lottery fashion, is a way that is accomplished in the United States.

The self-fulfilling prophecy may come into play here, as elsewhere. Given insurance, the attorney may name the librarian or institution as a party defendant. Insurance companies will advertise about the litigation hazard to build up premiums. And this will put in the mind of the public who will serve as jurors that the librarian or institution is covered by insurance. At trial, it may not be stated whether the defendant is or is not covered by insurance.

As final word, heed the Queen's advice to Alice in Wonderland: consider everything, and in the struggling with the challenge, don't get too depressed.

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LEGAL AND ETHICAL ISSUES INVOLVED IN HEALTH EDUCATION

Theodore Goldberg

I have been asked to begin a discussion of the ethical issues involved in the delivery of health care services by presenting a brief description of some of the legal and ethical dimensions of patient participation in the medical care process, with particular attention to the legal and ethical issues involved in patient education.

The usual approach to description of the legal basis of medicine is to talk about the rights and obligations of the physician in treating the variety of symptoms which are brought to her or him by the sick patient. Attention is given to the process of licensure (which bestows a legal monopoly on providing the services defined as "medical care" services), to the establishment of a doctor-patient relationship (with the concomitant potential legal problem of abandonment), to questions of negligence, assault and battery, informed consent, and the like. In all cases the focus is upon what is done for or to the patient, or even what has been neglected to be done. There is very little notice given to the patient's role in the process, including both his and her rights and responsibilities. The fact that we take this one-sided approach, both to the legal basis of medicine, and as reflected in what we identify as important ethical issues, may very well be a reflection of our basic view that medical care of "health care", if one is more inclined to prefer the broader, more encompassing term, is basically directed at attending disease and "curing" illness. Thus, we are concerned with establishing a legal framework to identify a set of rights, responsibilities, and requirements which provide a protection for those providing as well as those receiving health care services. The legal foundation establishes the physician's right to practice medicine, but goes far beyond this in identifying his or her duties, how violations or transgressions will be disciplined among health professionals, and the like, but not in a very extensive way. The law largely is concerned with protecting the patient against unwarranted intrusion and in assuring that physicians

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acquire and maintain acceptable levels of technical ability and performance. The law is concerned with identifying acceptable levels of performance and in judging whether these levels have been violated. It is as if we believe that the process of curing any disease can be identified and described accurately and comprehensively and that it is the physician's responsibility to follow the established procedures and to achieve the desired results. Thus, the basis for dissatisfaction, which frequently results in legal proceedings, is the claim that the desired results were not forthcoming which indicated that the provider somehow violated his legal responsibility to adhere to the accepted course of action which would have resulted in cure and satisfaction. Thus, the charge of incompetence, or malpractice, is either from neglecting to take needed action, or in engaging in the wrong actions, or in not advising the patient of likely or possible consequences, or in not achieving promised results, or in a whole variety of other complaints, usually directed at charging the provider with commiting certain deleterious acts or failing to perform certain needed actions. But the emphasis is on whether a clinical service was or was not performed or whether it was or wasn't performed adequately.

Now,there is nothing wrong with trying to establish a basis for judging satisfactory clinical performance and for protecting patients against practitioners who do not meet these standards. The problem is that when we concentrate so narrowly on this one element of what affects health status, two results are likely to occur:

First, we inadvertently leave the impression that there is a cure for every ailment, if only the physician is adequately trained and properly motivated, and

Second, that we tend to medicalize the natural process of aging and tend to look for medical solutions for problems which oftentime are social or even ethical.

But probably what is of greatest concern is that we are apt to overemphasize, perhaps it would be accurate to say "oversell", what the physician can accomplish, in terms of improving health status, with his limited armamentarium of diagnostic and therapeutic procedures. It very well may be that we have so conditioned the consuming public to think in terms of cures and miracles that when such are not forthcoming, and forthcoming immediately, then something must be wrong with the provider.

But that simply is not how medical care works, nor is it what has the major influence on health status. With all due respect to the physicians in the audience, and to all my clinical colleagues in the medical school and elsewhere, the facts of the matter are that while medical care services obviously are

important, and have, probably since the period of the Second World War, literally made substantial difference between life and death, they are not the major factor impacting on the health status of the American people. There is increasingly accumulating evidence that factors such as economic circumstances, health education and general attitudes have substantially a greater impact on health status and even mortality than does the number and kinds of medical care services that are utilized. In other words, it is environmental factors and self-imposed risks which have the largest influence on levels of health. It is what we do to or for ourselves that makes the most difference on how long we live and on how "well" we are during our lifetime. It is how we use and misuse and abuse drugs, and alcohol, and cigarettes that has the greatest influence on our state of health.

Add to this the whole question of how we abuse our bodies either through over-eating or by eating the wrong foods or through lack of exercise or recreation, and the evidence mounts to point to such self-imposed risks as the leading causes of mortality and morbidity. And if we also include careless driving and failure to use seat-belts, we have identified the main causes of our leading killers: heart attacks, cancer, strokes, and accidents.

It is not lack of technical know-how nor lack of access to medical services that produces the highly undesirable results on our health. We obviously know the deadly consequences of our modern life style and behavior, but that doesn't seem to make much difference in influencing changes in those things which are most harmful. And it certainly isn't that physicians are incompetent in what they have identified as their responsibilities that is causing the trouble. The problem more likely is to recognize that medicine must go beyond simply responding to the demands for acute care and must embrace preventive medicine and health education as more effective tools with which to deal with our major health threats. Unhealthy life styles will be little affected by improved diagnostic or therapeutic techniques. But they can be influenced by re-educating people to lead healthier lives. Reducing highway speed limits to 55 miles an hour undoubtedly did more to decrease accident fatalities than all the extremely well-trained teams of surgeons who labor over the crushed and broken bodies brought to them from the highways. Our efforts to reduce infant mortality will be helped more by our efforts to reduce teenage pregnancy than by all the increases, as useful as they might be, in providing earlier and more comprehensive pre-natal care.

But the real problem is, "How do we achieve greater success in our health education and preventive medical programs?" This is a tough question to answer and no one seems to feel

terribly certain that he or she has the total answer. But we do know that the answer can't be that the problems will be solved by ignoring them. Nor is the answer to be found by asking the wrong questions. If the causes of our difficulties are to be found in the life styles we choose to lead and the environments in which we live and work, then surely efforts to improve our health status must also be accomplished in these same areas. It is not that physicians are either incompetent or improperly motivated. It is that they are so submerged and bogged-down with illness, that they have lost sight of the fact that their goal is the attainment and maintenance of health. And so long as we continue to emphasize the treatment of disease as more important than the encouragement of health; so long as we continue to acknowledge and compensate those who perform curative procedures more lavishly than we do those who provide preventive services; so long as we downplay the role of those who engage in health education; and so long as we define both the legal and ethical issues in health care as being only those involving the provision of curative health services, then so long will we continue to ignore the use of our best opportunity to improve the health of the American people.

But there is good and increasing evidence that public policy is being re-directed to increased emphasis on changes in lifestyle and greater attention to health education. H.E.W. Secretary Califano's crusade against smoking seems finally to be paying dividends. School based health education programs, like those adopted by the Detroit Board of Education, hold likely prospects for encouraging healthier attitudes and healthier behavior through the education process. Activities directed toward identification and assessment of health risk factors among target populations served by some medical groups, such as those identified with the Family Medicine Department of Wayne State University School of Medicine as well as the nation's leading H.M.O.'s, are other encouraging examples of some slight change in focus and emphasis.

But how encouraged can we really be? I'm encouraged when I see joggers and the "no smoking" signs and the commitment to weight reduction. I'm discouraged every time I pass the junior high playground and see how young they are when they become addicted to cigarettes, and see the junk foods in public cafeterias or consider the unhealthy environment in which many people live and work.

But on balance I think that the future is hopeful if not certain. And besides, so long as there are dedicated people who gather to find answers to the problems of health education, then I am sure that I am on the winning side.

REPORT OF INSTITUTE WORKSHOP A

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BASIC PREMISES

1. There is a recognized need for consumer health information (CHI)

2. An individual has the right to this information

3. Librarians recognize the responsibility of their profession to help meet information needs

Statement of Conviction

For a variety of reasons neither public nor health science libraries have been able to meet the consumer health information needs. Changes in the health care delivery system, and consumer interest have now created an impetus compelling librarians to take greater responsibility for consumer health information.

We, therefore, believe that health science librarians and public librarians should contribute toward meeting consumer health information needs in conjunction with health agencies and other members of the health care team.

BASIC ROLE MODEL

A proposed model for taking greater responsibility for providing consumer health information is as follows:

1. Public libraries should have a major responsibility for dissemination of consumer health information to the public

2. Health science libraries should have a major

responsibility for dissemination of information to their patient clientele

3. There should be jointly shared responsibility for:

   a) Working closely with local and regional libraries and health agencies to

      (1) set up coordinated information programs
      (2) determine subject gaps

   b) Endeavoring to develop bibliographic control of consumer health information materials
   c) Seeking to develop quality control of health information materials
   d) Evaluating resources, materials and programs

ISSUES WITH BROAD IMPLICATIONS

1. Fragmentation of services

   A major concern is the fragmentation of consumer health information activities at the local, regional and national levels. Therefore, there is a need for all providers to work together to:

   a) promote cooperation
   b) avoid duplication of materials and programs by identifying existing resources
   c) foster understanding of the roles of the various consumer health information providers
   d) bring resources together into consumer health information centers

2. Quality and relevance of materials and programs.

   Means should be established to:

   a) Assure that materials and programs accurately reflect current medical opinion
   b) Determine that materials and programs are relevant to the diverse educational and cultural needs of the clientele

3. Bibliographic Control

   Because of the multiplicity and diversity of consumer health information materials there is a critical need to develop bibliographic control at the local, regional and national level. Efforts should be made to:

   a) develop standards

b) prepare union lists
c) establish on-line data bases

4. Training and Education

Consumer health information requires special professional skills. For the effective provision of CHI services it is necessary to:

a) Encourage library schools to aid in the development of a new type of librarian
b) Urge all library schools to include an overview course which covers all types of professional libraries thus helping to prevent the parochialism that develops when professionals move into specialized fields
c) Develop awareness of the librarians' role in consumer health information by students in medical, nursing and allied health schools
d) Foster the development of on-going consumer health information programs including continuing-education activities by the Medical Library Association, the American Library Association and other professional library organizations
e) Inform health personnel and the general public of librarians' professional commitment to consumer health information

5. Organizational support

Librarians must make an effort to:

a) seek government support for consumer health information programs at the local, state and national levels
b) enlist the support of professional organizations such as the American Library Association, the Medical Library Association and the health professional organizations
c) seek the support and cooperation of volunteer agencies

6. Legal Implications

The legal responsibility of the librarian must be determined in regard to supplying health information.

7. Ethical Considerations

Librarians must develop a code of ethics concerned with the dissemination of consumer health information

CONSIDERATIONS FOR SPECIFIC MODELS

1. Administrative considerations (to be determined in the context of a given institution)

   a) Objectives of the program
   b) Clientele to be reached
   c) Appropriate sites for the programs
   d) Administrative support in initial stages
   e) Program and organizational planning
   f) Funding
   g) Delineation of responsibilities and roles
   h) Staffing needs

      (1) personnel requirements (number, paid or volunteer)
      (2) qualifications and job description
      (3) training (formal instruction, on the job training, continuing education)

2. Cooperative activities

   Sensitivity to the roles of everyone involved is necessary in order to gain acceptance of the role of the librarian. Cooperative activities could include:

   a) workshops
   b) newsletters, periodic meetings, and hotlines
   c) other available channels of communication

3. Collection and Dissemination Considerations

   a) cost
   b) acquisition
   c) format
   d) storage
   e) retrieval

4. Promotional activities

   a) continuous promotion within individual institutions
   b) informational activities for users (speakers' bureaus, newsnotes, flyers, advertising campaigns)

5. Evaluation

   a) Design of mechanisms for on-going assessment of objectives

      (1) for user
      (2) for provider

REPORT OF INSTITUTE WORKSHOP B

Dianne Lee Bish
Valerie Bindschadler
Margaret DuMouchel
Angelita Espino-McGhee
Bernard Finney
Thomas Risto
Mary B. Hubbard
Carole Hund
Kathleen Morrissey
Stephen Rybicki
Christopher Schim
Michael Wells

The public library accepts primary responsibility for meeting the patrons' health information needs and will make referrals when additional information or services are desired.

Growing consumer demand has necessitated an easily accessible place where information, materials, resources, community services and referrals concerning patron health education are available.

The public library can meet these needs and act as a catalyst in increasing utilization of area resources because of its non-vested interest in the health/medical arena.

General Goal

A better informed public in regard to general health education; the maintenance of well-being; and the recognition by the public that the library can provide health information both directly and indirectly.

Specific Objectives

1. To develop a core collection of materials to meet individual community needs, including a variety of print and non-print items, ranging from the basic to technical.

2. To establish systems to provide back-up, via inter-library loans and inter-library cooperation.

3. To establish referral systems which cover community resources, agencies, institutions, and organizations.

4. To develop programs which will enlighten and educate the public in regard to basic health care.

5. To educate consumers to regard public libraries as health resource centers.

Short-term Objectives

1. To seek grant support for seed money to establish a health education program.

2. To seek grants for in-service training and continuing education in order to provide staff which is knowledgeable concerning various forms of health care.

3. To acquire health care materials.

The institute has provided a forum for communication which may facilitate cooperation among many health libraries. We hope that there will be more.

REPORT OF INSTITUTE WORKSHOP C

Bernice Armstead
Holly Shipp Buchanan
Phyllis Cox
Pamela Drayson
Howard Epstein
Lorraine Ettl
Margaret Hardy
Metta Lansdale
Nardina Nameth
Elizabeth Sande

Carl Worstell

OUTLINE OF HEALTH INFORMATION PROGRAM UTOPIA MEDICAL CENTER

I. Setting of Utopia Medical Center

II. Basic Premises

III. Goals Statement

IV. Functional Chart

V. Objectives

- A. Services
- B. Resources
  1. Parameters of collection
  2. Criteria for selection
  3. Acquisition
  4. Organization
  5. Retention
- C. Promotion
- D. Cooperation

VI. Evaluation

Health Sciences Library
Utopia Medical Center
7 Camelot Drive
Paradise Valley, Mecca, U.S.A.

Health Information Program (HIP)

Utopia Medical Center is a health care facility providing medical and allied health education, and medical, surgical, and acute psychiatric care, through hospital and out-patient clinics.

The Medical Center's administration recognizes the basic rights of people to health information, sees health information as an integral part of total patient care, realizes that a need exists for such information, and accepts the role of provider of health information to its clientele. Consistent with accepting this role, necessary resources have been allocated.

BASIC PREMISES

1. Ideally, the health information system should be organized so that an individual may enter the system at any point, i.e. hospital library, medical school library, or agency; and receive appropriate information or referral.

2. Within this health information system, the public library's role is the provision of health information to the lay public; the medical center/hospital library's role is the provision of primarily lay medical information to patients and their families.

3. In order to provide information to people throughout the total range of health care, there should be a close working relationship to optimize the use of all resources.

4. Patient teaching should be the role of the health professional involved in direct patient care. The hospital library's primary role lies in the provision of library services to these health professionals.

5. The librarian's role is seen as innovative, active and assertive rather than merely reacting to expressed needs.

Goal

To provide health information to health professionals and to enable lay persons to better understand their health problems and to promote more healthful lifestyles.

Priority of Clientele to be Served

1. Health professionals and students in the clinical setting.
2. Patients and family members referred by health professionals.
3. Staff from other libraries and agencies.
4. Patients and family members on self-referral.
5. General public on referral from other libraries and agencies.
6. General public on self-referral.

Objectives

1. To provide health information services to our clientele.
2. To serve as a centralized resource center for health information materials.
3. To promote and publicize the Health Science Library's health information activities.
4. To cooperate with other types of libraries and agencies in the region.

Objective #1:

To provide health information services to our clientele.

Activities

1. Reference service shall be provided, appropriate to the request.
2. Document delivery service shall be provided to:
   a. health professionals

b. patients and families
c. community agencies and libraries
d. general public

3. Referral shall be made to appropriate resources or service.

4. Provision shall be made for audiovisual services and programs, including Closed Circuit Television.

5. A separate area shall be provided for patient use.

6. Consulting services shall be provided to health professionals engaged in patient teaching.

Objective #2:

To serve as a centeralized resource for health information materials.

Parameters of the UMC Health Information Collection

1. A health information core reference collection, to be duplicated in area public libraries.

2. A comprehensive collection of print lay materials on diseases and treatments. Other agencies, including the public library, will depend upon the Health Sciences Library for these materials.

3. A selective audiovisual collection for disease and treatments encountered at UMC. Public libraries and agencies may borrow items.

4. A health maintenance and/or disease prevention collection (print and audiovisual) supporting UMC programs. The public library will provide the same for the general public as well as for subject areas not covered by clinics.

5. Health maintenance and/or disease prevention literature will be distributed to patients discharged from hospitals or clinics, in packets.

Selection Criteria

Information will be selected on both an anticipatory and a reactive basis, consistent with established selection policy.

1. Anticipatory

   a. discharge diagnoses will be examined to determine the areas of collection development.
   b. selection will be made in response to health care trends.
   c. selection will be made in response to mass media trends.

2. Reactive

   a. selection will be made supporting existing lay health information programs at UMC.
   b. selection will be made in areas shown as deficient by unanswered reference questions, etc.
   c. selection will be made in response to patients' evaluations of material.

Acquisitions

1. Purchase will be done in sufficient bulk to allow take-home materials.

2. Material will be acquired appropriate to

   a. language needs
   b. comprehension level
   c. audiovisual format

Organization

1. All material will be cataloged.

2. Cards for materials will also be filed at the public library, and vice versa.

Retention

An active weeding policy will maintain current space requirements, accuracy and currency.

Objective #3:

To promote and publicize the health science libraries' information capability.

Activities

1. Acquisitions list
2. Activities with local library groups including continuing education ventures
3. Annual reports to administration and the public (also other relevant publications)
4. Closed circuit television
5. Committee participation: nursing, library and health education
6. Fund raising, from public and private sources
7. Information sheet on how to use the library
8. Inservice education on the health literature for various groups within the hospital and in community groups
9. Lobbying for sympathetic legislation in cooperation with library groups
10. Newsletter (monthly)
11. Posters
12. Public service announcements on radio, newspapers and television

Target audience

1. Administrators
2. General public
3. Health agencies and public service agents
4. Health professionals
5. Patients
6. Public librarians
7. Third party payers (insurance companies)

Objective #4:

To cooperate with other types of libraries and agencies in the region.

Activities

1. Formal establishment of a referral system allowing a person to enter the system at any point, e.g., as a patient, out-patient, through the public library, the American Cancer Society, Tel-Med, etc.

2. Formal Interlibrary Loan agreement among defined cooperating agencies.

3. Cooperative holdings lists to include serials, monographs, and audiovisuals.

4. Coordinated acquisitions policies (see Objective #2).

5. Workshops for public librarians and for health science librarians, such as the following:

   a. how to use medical reference tools
   b. how to use appropriate public library reference tools
   c. on-line services
   d. reference interview techniques
   e. selection techniques

6. Directory of agencies, services, personnel

7. Regular meetings among cooperating libraries and agencies, for example:

   a. advisory council made up of libraries, agencies, government representatives and community members
   b. general membership meetings

8. Clearinghouse functions:

   a. subject concentrations
   b. media forms
   c. directory information
   d. bulk pamphlet purchases

9. Cooperation with community health education programs.

Evaluation

Ongoing evaluation studies will be performed through the use of user surveys and other data collection methodology.

CRITIQUE OF WORKSHOP PROPOSALS

Resource Panelists

William Leavens
Norman Maas
Rita Lorden
Peggy Turner
James Williams II
Betty Rusnack

Ruth Taylor, Recorder

Commendations

Proposals reflect a comprehensive synthesis of papers/ lectures/ corridor time.

Proposals express strong commitment to a librarian's role in (a) the dissemination of health information, (b) the provision of health information, (c) the development of a systematic approach, regardless of setting.

Proposals identify the need to develop broad-based informational delivery systems involving a variety of agencies--hospitals, libraries, voluntary health agencies, educational institutions -- within a network.

Proposals identify the fact that provision of health information is a form of health education.

Participants see themselves in a transactional process with other health care providers -- individuals working with other individuals toward a common goal.

Proposals identify the need to provide health information for individuals and groups with differing learning needs.

Proposals address the difference between providing information and advising.

Proposals are realistic in identification of the need for fiscal resources to support programmatic activities.

Proposals identify the activities which can be implemented with existing resources.

Recommendations

Planners should address the distinction between health education and health information.

There should be a strong expression of an active advocacy role on the part of librarians.

Planners should be specific in terms of who is perceived as clientele.

Planners must address their specific information needs once the client population is determined.

Definition of terms should be more precise.

Planners should program for small successes in order to receive immediate rewards.

Planners should be aware that networking involves behavior change and is accomplished over considerable time spans.

Suggestions to Participants

The widest range of viewpoints on a particular subject must be offered in the provision of health information. Be aware of your personal preferences, prejudices and opinions.

On your return home, seek out people supportive of your objectives who will work with you to accomplish those objectives.

EVALUATION REPORT
Donald R. Marcotte

Introduction

This evaluation report focuses on the perceptions of participants who attended a five-day pilot United States Office of Education Institute on "Patient/Health Education: The Librarian's Role" conducted at Wayne State University, Detroit, Michigan, from February 4 through February 9, 1979.

The basic evaluation design consisted of a pre- and post-measurement of perceptions. The instruments used to the pre- and post-measurements were purposely not identical. The pre-measurement focused on (a) the collection of demographic information, (b) needs for lay health information, (c) perceptions (consisting of three sections: Hospital In-Patients and Out-Patients, Laypersons--General Public, and General), and (d) participant-written general perceptions. The post-measurement consisted of perceptions (the same three sections given for the pre-measurement, plus an additional section on Institute perceptions), and participant-written general perceptions.

The pre-measurement instrument was mailed to those individuals who were selected to attend the Institute. Thirty individuals returned the completed pre-measurement instrument. Upon completion of the Institute, thirty-three individuals completed the post-measurement instrument. Tables 1 through

---

Donald R. Marcotte, Ph.D., is Professor, Educational Evaluation and Research, College of Education, Wayne State University.

14 represent the results of the analyses of both instruments.

Results

It can be seen from Table 1 that the majority of participants were either health science librarians (hospital and university medical division) or public librarians.

TABLE 1

INSTITUTIONAL AFFILIATION OF INSTITUTE PARTICIPANTS
(N=33)

Type of Library	Frequency	Percent
Hospital Library	14	43
Public Library	8	24
University Library (Medical Division)	5	15
State Library	3	9
Community College Library	2	6
Health Agency Library (Dental)	1	3

It is also evident from the table that there was a diversity of representation from the profession. Tables 2 and 3 respectively indicate that the range in years of experience (less than one year to more than fifteen years) and geographic representation (all geographic parts of the country) were both widespread.

Thirty-six percent of the mail respondents indicated that they had experience with patient/health education other than those university, hospital, or institute training, as shown in Table 4. Only 20 percent indicated that they had no

TABLE 2

LIBRARY EXPERIENCE OF INSTITUTE PARTICIPANTS BY YEARS
(N=30)

Years of Library Experience	Frequency	Percent
Less than 1	1	3
1-5	10	33
6-10	11	37
11-15	5	17
More than 15	3	10

TABLE 3

GEOGRAPHIC DISTRIBUTION OF PARTICIPANTS
(N=33)

Area	Frequency	Percent
California	1	3
Colorado	1	3
Illinois	2	6
Iowa	1	3
Kentucky	1	3
Michigan	12	36
Minnesota	2	6
Missouri	1	3
New York	4	12
North Dakota	1	3
Ohio	2	6
Pennsylvania	1	3
Tennessee	1	3
Texas	1	3
Virginia	1	3
Washington	1	3

experience with patient/health education. It is interesting to see that only 27 percent had training in a university,

hospital, or institute setting. The intent of the question was to identify background preparation for providing lay health information. The phrasing of the question on the pre-instrument proved to be ambiguous and the conclusions would need further testing.

TABLE 4

PREVIOUS PREPARATION FOR PROVIDING PATIENT/HEALTH EDUCATION (N=30)

Type of Preparation	Frequency	Percent
University Training	4	13
Hospital Training	2	7
Institute	2	7
No Response	5	17
None	6	20
Other		
Reference experience in a library: MLA Continuing Education; Workshops, Panels/Speeches/Seminars; CHIPS Project; Personal Reading		

Eighty percent of mail respondents indicated that provision of health information in their libraries was made on the direct request of laymen, as given in Table 5.

Table 6 indicates the status of the persons seeking patient/health information from the libraries represented. Seventy-three percent of the respondents indicated that laymen seek information from their libraries. When Tables 1 and 6 are correlated, it becomes clear that laymen look to various

kinds of libraries to fill their health information needs.

TABLE 5

CONDITIONS FOR PROVIDING HEALTH INFORMATION DIRECTLY TO LAYMEN
(N=30)

Conditions	Number of Libraries	Percent
On layman's request	24	80
On referral from physician	15	50
On referral from nurse	9	30
On referral from social worker	8	27
On request of students, faculty	1	3
On referral from other libraries	2	6
None	1	3

TABLE 6

CLIENTELE SEEKING PATIENT/HEALTH INFORMATION
(N=30)

Status of Laymen	Number of Libraries	Percent
Patients in hospital	13	43
Outpatients in hospital	13	43
Families of patients in hospital	17	57
General public	22	73
Not applicable	1	3

The provision of printed materials was generally made to nurses, to physicians, and directly to patients, as is shown in Table 7. Printed materials were provided to social workers and health information agencies on a somewhat less

frequent basis.

TABLE 7

CLIENTELE TO WHOM LIBRARIES SUPPLY PRINTED MATERIAL
BY CLIENT AND BY TYPE OF LIBRARY
(N=30)

Client	Number of Libraries	Percent
Patients directly	15	50
Health information agencies	10	33
Physicians	16	53
Nurses	18	60
Social workers	14	47
None	1	3
Not applicable	1	3
Families of patients	2	7
All employees directly involved in patient care	3	10
General public	5	17
Faculty	1	3
Other libraries	3	10
Students	3	10

When asked to rank order major concerns (see Table 8) and Table 9), mail respondents ranked "Selection of materials", "Acquisition of materials", and "Relations with health care personnel" as most important. "Organization of materials", "Referral of laymen to health care agencies", and "Relationships with voluntary health care associations" were considered of least importance.

Table 10 shows that 53 percent of the mail respondents indicated that the library provides materials to support a program of patient/health information. Forty-three percent

TABLE 8

RANK ORDER OF MAJOR CONCERNS OF INSTITUTE PARTICIPANTS
(N=20)

Major Concern	1		2		3		4		5		6		7		8	
	f	%	f	%	f	%	f	%	f	%	f	%	f	%	f	%
Selection of materials	8	40	5	25	2	10	2	10	1	5	1	5	1	5	0	0
Acquisition of materials	1	6	5	28	5	28	1	6	4	22	1	6	1	6	0	0
Organization of materials	0	0	1	5	3	15	5	25	6	30	2	10	0	0	0	15
Retrieval of materials	1	5	0	0	2	10	7	35	3	15	1	5	6	30	0	0
Relationships with health care personnel	7	35	2	10	2	10	1	5	1	5	3	15	1	5	3	15
Relationships with voluntary health care associations[a]	0	0	0	0	0	0	2	11	1	6	3	17	7	39	5	28
Ethical/Legal dimensions of interpreting information	3	15	4	20	2	10	2	10	0	0	6	30	0	0	3	15
Referral of laymen to health care agencies	0	0	1	5	4	20	0	0	4	20	3	15	4	20	4	20
Other[b]	1	20	2	40	0	0	0	0	0	0	0	0	0	0	2	40
Library cooperation																
Promotional activities																
Physician acceptance of concept																

[a]Rank of nine assigned in two cases.

[b]Based on N=5.

indicated that there was no such provision.

TABLE 9

RANK ORDER OF MAJOR CONCERNS OF INSTITUTE PARTICIPANTS MULTIPLE RANKS
(N=10)

Major Concern	Individuals									
	1	2	3	4	5	6	7	8	9	10
Selection of materials	1	1	1	1	1	1	1	1	4	1
Acquisition of materials	1	2	1	1	2	-	3	3	9	9
Organization of materials	5	5	1	1	3	4	1	1	6	1
Relationships with health care personnel	5	6	1	3	-	-	2	1	1	9
Relationships with voluntary health care associations	6	7	7	9	-	-	7	1	3	9
Ethical/Legal dimensions of interpreting information	1	3	8	3	-	-	8	1	3	1
Referral of laymen to health care agencies	1	8	1	9	-	-	3	1	1	9
Other	-	1	-	-	X	-	-	1		
Evaluation of materials										
Providing health care information to health care and other libraries for their patients										
Outreach to general public										

TABLE 10

LIBRARY PROVIDES MATERIALS TO SUPPORT A PROGRAM OF PATIENT/HEALTH INFORMATION
(N=30)

Response	Frequency	Percent
Yes	16	53
No	13	43
Not applicable	1	3

Perceptions

There were four statements on perceptions related to "In- and Out-Patient (Hospital)" that were pre- and post-administered to the respondents. The greatest change occurred for the statements:

> The nurse has a responsibility for patient/health information dissemination, and
>
> The social worker has a responsibility for patient/health information dissemination.

For each of these statements, there was more agreement on the part of the respondents after the institute than before the institute. It can be seen from Table 11 that the respondents agreed that the physician, nurse, social worker, and librarian all had responsibility for patient/health information dissemination for the category "In- and Out-Patient (Hospital)".

Table 12 contains the results to four statements on "Layperson--General Public". Once again, there were changes for two of the four statements:

> The social worker has a responsibility for patient/health information dissemination, and
>
> The librarian has a responsibility for patient/health information dissemination.

For each of these statements, there was more agreement after the institute than before the institute. It can also be seen from the table that the respondents felt that the librarian was the primary person responsible for patient/health information dissemination to the layperson. Following the librarian were physician, social worker, and nurse respectively.

TABLE 11

PERCEPTIONS OF INSTITUTE PARTICIPANTS AS TO RESPONSIBILITY FOR PROVIDING HEALTH INFORMATION TO IN-PATIENTS AND OUT-PARIENTS (HOSPITAL)
(N=30--BEFORE; N=33--AFTER)

Statement	Agree		Neutral		Disagree		NR[a]		Administered
	f	%	f	%	f	%	f	%	
The physician has a responsibility for patient/health information dissemination	23	77	5	17	1	3	1	3	Before
	29	88	3	9	1	3	0	0	After
The nurse has a responsibility for patient/health information dissemination	18	60	9	30	2	7	1	3	Before
	28	85	4	12	1	3	0	0	After
The social worker has a responsibility for patient/health information dissemination	12	40	15	50	2	7	1	3	Before
	24	73	8	24	1	3	0	0	After
The librarian has a responsibility for patient/health information dissemination.	21	70	7	23	1	3	1	3	Before
	29	88	4	12	0	0	0	0	After

[a]No response.

TABLE 12

PERCEPTIONS OF INSTITUTE PARTICIPANTS AS TO RESPONSIBILITY FOR PROVIDING HEALTH INFORMATION TO LAYPERSONS--GENERAL PUBLIC
(N=30--BEFORE; N=33--AFTER)

Statement	Agree		Neutral		Disagree		NR[a]		
	f	%	f	%	f	%	f	%	Administered
The physician has a responsibility for patient/health information dissemination	17	57	10	33	1	3	2	7	Before
	21	64	9	27	3	9	0	0	After
The nurse has a responsibility for patient/health information dissemination	11	37	15	50	2	7	2	7	Before
	17	52	14	42	2	6	0	0	After
The social worker has a responsibility for patient/health information dissemination	8	27	15	50	5	17	2	7	Before
	19	58	13	39	1	3	0	0	After
The librarian has a responsibility for patient/health information dissemination	24	80	3	10	2	7	1	3	Before
	32	97	1	3	0	0	0	0	After

[a]No response.

Ten statements on general perceptions were administered to the participants on a pre-institute and post-institute basis. The responses to these statements are given in Table 13. Changes occurred for three of the ten statements.

1. There is a nationwide effort to develop programs to educate the lay public concerning the right to obtain public health information
2. The public librarian can assist the public by providing the most reliable, accurate, and up-to-date lay medical material
3. Public librarians are uneasy about providing public health information.

There was less agreement on statements one and three after the institute, and there was more agreement on the second statement after the institute.

Table 14 contains seven statements on post-institute perceptions. In general, there was agreement on six of the seven statements as is shown below (percentage reflects the combining of the strongly agree and agree categories):

It is possible to organize a Medical Information Center in such a way as to be responsive to the need for a wide variety of medical information.	100%
It is possible to assess the kind and extent of training necessary for the librarian to act as an intermediary in the transfer of health/patient information.	97%
Ways in which librarians can participate fruitfully with major deliverers of health information--the physician, the nurse, the social worker, the voluntary associations--were identified.	91%
The librarian can support the physician in the interpretation of medical diagnoses, treatment modalities, and prognoses for the patient and for his family, through the	88%

TABLE 13

GENERAL PERCEPTIONS OF INSTITUTE PARTICIPANTS
(N=30--BEFORE; N=33--AFTER)

Statement	Agree		Neutral		Disagree		NR[a]		Administered
	f	%	f	%	f	%	f	%	
There is a nationwide effort to develop programs to educate the lay public concerning the right to obtain public health information	17	57	8	27	5	17	0	0	Before
	7	21	20	61	6	18	0	0	After
If a patient has a question concerning health and treatment, the only resource available is his/her physician	0	0	8	27	22	73	0	0	Before
	0	0	5	15	28	85	0	0	After
Health information should be provided exclusively for health professionals	0	0	1	3	29	97	0	0	Before
	0	0	1	3	32	97	0	0	After
The public librarian can provide a definite service by interpreting public health information to the public	5	17	10	33	14	47	1	3	Before
	8	24	10	30	15	45	0	0	After
The librarian plays an important role by being able to assist the patient in interpreting a diagnosis	2	7	6	20	22	73	0	0	Before
	2	6	12	36	19	58	0	0	After
The public librarian can assist the public by providing the most reliable, accurate, and up-to-date lay medical material	23	77	5	17	2	7	0	0	Before
	31	94	2	6	0	0	0	0	After

TABLE 13--Continued

Statement	Agree		Neutral		Disagree		NR[a]		Administered
	f	%	f	%	f	%	f	%	
If the librarian refuses to provide medical information, the individual requesting the information has grounds for legal recourse	5	17	12	40	13	43	0	0	Before
	5	15	5	15	22	67	1	3	After
Public librarians are uneasy about providing public health information	16	53	12	40	1	3	1	3	Before
	13	39	18	55	2	6	0	0	After
The general lay public is not capable of evaluating health information	1	3	14	47	14	47	1	3	Before
	3	9	10	30	19	58	1	3	After
If the librarian provides inaccurate medical information, the individual requesting the information has grounds for legal recourse	3	10	10	33	15	50	2	7	Before
	0	0	15	45	17	52	1	3	After

[a]No response.

TABLE 14

POST-INSTITUTE PERCEPTIONS OF INSTITUTE PARTICIPANTS
(N=33)

Statement	Strongly Agree		Agree		Disagree		Strongly Disagree		NR[a]	
	f	%	f	%	f	%	f	%	f	%
The role of the librarian in both supplying and interpreting information to the lay public was clearly distinguished	15	45	13	39	2	6	3	9	0	0
Ways in which librarians can participate fruitfully with major deliverers of health information--the physician, the nurse, the social worker, the voluntary associations--were identified	21	64	9	27	2	6	1	3	0	0
The librarian can support the physician in the interpretation of medical diagnoses, treatment modalities, and prognoses for the patient and for his family, through the provision of access to the lay level informational materials which exist	22	67	7	21	3	9	1	3	0	0
The responsibility of the librarian, legally and ethically, in the providing and interpreting of information is recognized	11	33	8	24	4	12	8	24	2	6

TABLE 14--Continued

Statement	Strongly Agree		Agree		Disagree		Strongly Disagree		NR[a]	
	f	%	f	%	f	%	f	%	f	%
The position of the librarian can be defined both legally and ethically if access to medical information is refused	8	24	5	15	7	21	11	33	2	6
It is possible to organize a Medical Information Center in such a way as to be responsive to the need for a wide variety of medical information	32	97	1	3	0	0	0	0	0	0
It is possible to assess the kind and extent of training necessary for the librarian to act as an intermediary in the transfer of health/patient information	14	42	18	55	0	0	1	3	0	0

[a]No response.

provision of access to the lay level informational materials which exist.

The role of the librarian in both supplying and interpreting information to the lay public was clearly distinguished. 84%

The responsibility of the librarian, legally and ethically, in the providing and interpreting of information is recognized. 57%

There was 54 percent disagreement on the statement:

The position of the librarian can be defined both legally and ethically if access to medical information is refused.

It is clear from the above that the institute did not resolve the issue related to legal and ethical provision of information to everyone's satisfaction.

Written General Perceptions

Participants in the institute were encouraged to provide written general perceptions both prior to and after the institute. These perceptions are typed exactly as they were written on the instruments.

General Perceptions Before the Institute

I do not perceive enthusiasm for patient education as far as the library is concerned, in my hospital among administration and physicians. I must sell it when I return from the Institute. (Our Nursing Educational Services does a great deal of patient education but the library is not involved.)

The word librarian should be clarified. I never could tell when you were referring to public library or health care facility library and I believe the two have distinctive roles. What is meant by "medical information"? Interpretation of the literature or the sources of the information.

The general public health consumer has a responsibility to be well informed about his health just as he is about gasoline and grocery prices. Health practitioners have responsibility to provide information as part of their therapeutic regimen. Both groups.

Teaching facilities have the responsibility to provide texts and related material in sufficient quantities to meet students' needs readily. Public libraries should not have to support class assignments. Public libraries are in the uncomfortable position of sometimes feeling obliged to meet a popular demand for questionable health-related books. A public library, relative to the community it serves, should provide a reasonable scope of health-related materials--from the standpoint of the subject's being part of the general body of knowledge. In selection/acquisition, the library should consider of the materials to the public as a whole rather than to special interest groups. Esoteric and/or unusually scholarly books/journals should be available through special libraries/resource centers. In my experience, the chief responsibility of a medical library in a university or hospital has been to provide professional books/journals and related materials for the staff and students of its own closed "community". However, within a consortium, network, or by means of other reasonable guidelines, large medical libraries should cooperate with public libraries in providing needed information. The librarian's professional expertise is in locating information. He/she is rarely a certified specialist in diagnosis or therapy, and it is the librarian's responsibility, at most, to quote, not interpret. The full burden of responsibility for interpretation must lie with the inquirer. If that is a lay person, hopefully he/she will consult with a physician or other qualified health professional in case of any doubt. The public librarian frequently recommends this. The general public has a right to health information. The public librarian has little concern about making available a wide spectrum of material--from from scholarly to questionable for the layman who has the intelligence, background, perception, and judgment to sift the wheat from the chaff and who may even want to read all of the "chaff" merely out of curiosity or to be really informed about what a questionable writer is saying. What is of great concern to the public librarian is the gullible, undiscriminating perhaps intellectually dull reader for whom "a little knowledge is a dangerous thing" and who can do himself bodily harm by attempting

self-diagnosis and treatment. There is no way to control this in a public library with a liberal open shelf, "freedom to read" policy. In recent years, because of the proliferation of training programs for health technicians and other paraprofessionals, the public library has been faced with broadening the scope and depth of its health/medical collection to meet the demands of this broad segment of patrons who want to do "one-stop shopping" at the public library for both professional and recreational reading. The demand for science project material has been instrumental in making available to young people materials which formerly were restricted to adults only without parental permission.

In my opinion, the librarian's role is that of an information provider, not an interpreter of diagnoses or of the information--.

The librarian's role in the delivery of patient/health library services is gaining momentum in New York State and we are concerned that all persons who might be confined have access to the rich resources of the library. Hopefully, by my attending this institute on Patient/health Education: The Librarian's Role, it will enable the State Library to take a role in bringing together the various health care organizations and personnel to understand the linkage between them and the librarian. Additional strenthening of patient/health services in New York State can be achieved through development of regional workshops.

The Science/Health Sciences/Technology staff of the New York State Library are not allowed to interpret public health information to patrons, but to guide them in finding it, and to try to supply adequate information on subject requests through interlibrary loan. We do not, usually, purchase materials for the lay public, leaving that to the public librarian. We are a libraries' library, for the most part. To the on-site patron, we are a research/resource library.

My chief concern is with the problem of disseminating or circulating the lay health materials which we have and are (modestly) budgeted to add. Although my patrons are hospitalized, they are seldom motivated to read about their bodies or their ailments. They may turn to the nurses for health information, but I have not found the way to inspire the nurses to refer them to library materials. What would be some

successful means of awakening this latent clientele? I am also concerned with developing a better health collection, but at the present usuage rate it is discouraging. What a librarian can do to inspire, stimulate, rally, support with more than materials a Health Education program with his understaffed, unfunded, and supported only mildly by hospital administration--that is the challenge I scarcely feel equal to.

I think that the librarian should have health materials available for the lay person that are understandable to him. The librarian should not be responsible for interpreting materials as far as diagnosis or prognosis is concerned. That is only for the patient's physician to do.

General Perceptions After the Institute

The rather sharp division that appears to exist between medical and public librarians' commitment to provision of P/H/Info (I'm referring to the fact that so few public librarians applied to the Institute--those who came were, of course, committed) reveals a need for extra efforts on the part of medical librarians: to make initial contacts with public librarians on this issue, to offer referral services and cooperation in dissemination of materials. One of the matters the Institute has, perhaps inadvertently, addressed is inter-professional roles.

The thing that disturbed me most is that in determining what segment of the population will be served, a large segment will probably not be served. These are the poor, illiterate persons (black, white, etc.) who probably need help more than those who read on the fifth grade level. On the other hand I guess all is not lost. I hear doctors and residents, etc. say that in dealing with Clinic patients it is necessary to educate them so that they can effectively treat them. I feel that the institute addressed all areas of the subject thoroughly. I came away with very positive ideas on how to procede in furthering Patient Education. I have, also, been able to get The Mid-Tennessee Health Science Librarians to sponsor a mini workshop in April on the subject.

There should be some mechanism for input into the physician community of this institute and it would be hoped that the proceedings of this institute

somehow become a part of the input for the White House Conference and that it be used as a mechanism to influence NLM to fund joint health sciences public library patient/health education projects with particular emphasis on consumer education. I would also like to see the proceedings distributed to all state librarians. I intend to report to my public librarian but I feel the information needs to come from both ends.

The need for cooperative efforts among various institutions is of tantamount importance.

I find Section D semantically confusing and answered per my interpretation of request. The philosophy of consumer health information received major emphasis at the conference. However, there are no hard and fast definitions of legal responsibility at this point. A great many issues were identified but are still open to interpretation. In answering #21, merely support. Few librarians have the medical background to "interpret" medical literature. The role of interpretation lies with the primary medical providers. (The Institute was well organized and thought provoking. The opportunity to interact with both public and medical librarians was important. If the Institute is offerred again, the contents of the program should be explicit. You might want to offer an introductory course such as this but also consider a more advanced course. I was disappointed that Eleanor Goodchild, a participant, was not instead of a participant, a primary speaker as she has had more expertise in the field than any of the other library speakers. I would also have preferred more emphasis on availability of materials, the evaluation of them and proposals for finding seed money to set up union lists or data bases. If the Institute had spent less time on philosophy this could be possible. The other possibility would have been two sessions--introductory and advanced as mentioned above. I commend the Institute for all the planning and organization and think it is a great beginning.

Very great mental stimulation was provided by this week. There was frustration that no tangible benefits can be carried home. The idea load is fragile and takes time and opportunity to display. Especially in the area of materials--sources, evaluations, formats, content, levels, etc.--a felt void could have been addressed in a far different way. The intangibles with which I am enriched are numerous and

valuable: a sense of dedication, an increased concern, a new and broader perception of problems and prospects, insights of many kinds. Altogether very pleasurable and profitable.

Very good Institute! I am glad to have had the chance to attend and participate. The whole issue is such a fuzzy one and one fraught with some many potential trouble areas, that there will need to be much more clarification of the librarian's role--but an excellent start! One aspect that had both pros and cons was the diversity of experience among participants. If it could have been assumed that there was a bit more of a background in the future directions of the health care system and health promotion, we could perhaps have heard fewer speakers address (and belabor!) this point. Instead, I have liked more of a discussion on the theoretical aspects of health education and where health information fits in. This type of discussion/interaction would perhaps have helped clarify how librarians can participate. The workshop sessions were OK--an interesting process--again for big divergence of participants created somewhat of a problem--smaller groupings may have facilitated the process. More of a dialogue on cooperation between publics and medicals would also have been a good addition. Thanks again for your efforts in pulling the Institute together.

1. Note all pub. libraries represented were from a two hundred mile radius of Detroit. 2. CHIPs should have been discussed more because it is a working model.

Many of the questions that have been raised in the conference have enlarged my views and awareness of the issues. However, my perception of the librarians role and of the health professionals role in providing health care information to the lay person remains the same as when I came. I perceive a strong need by the public and the responsibility to supply, must be accepted by the whole group of people identified at various times during the conference. The method of supply must be developed, and I see the librarian as catalyst in this development.

The public library can play an integral part & role in the delivery of library service to Patient/Health care, based on interface with other health related organizations.

It is a disappointment that more public librarians were not interested in attending this Institute. Health information is already being supplied in great quantity by the public library, it is through education in various special areas that the element of "fear" will be lessened. (This Institute was an excellent example of the educational process that should be an on going continuing education goal.)

I feel that we are still unsure about the librarian's role as this relates to the question of providing information or education, however I do not see any confusion as to the fact that librarians have a major role in the provision of access to information.

Without cooperation of agencies disseminating information--medically oriented & publically oriented the effort will not be successful.

I think the most important thing that came out of this conference for me is an understanding of the roles of public and hospital libraries in the provision of health information. It is my goal, as the incoming president of MDMLG, to begin an active dialog with the staff at DPL so that real cooperation can develop.

My perceptions are concerned with the ability of non-assertive librarians to carry out any change as threatening and undefined as presented here. Only history will tell.

I have checked the above scales according to my perceptions and understanding of the terminology used in the statements, which may or may not be in line with the intent of those who designed the questionnaire--It seems to me that we should address the need that exists for health and medical information from a positive stance, rather than from fear and concern that progress cannot be made. We need to start wherever and however we can and not be defeated by the very real problems and concerns that we know exist--Well-intentioned people working together can solve a multiplicity of problems and move forward in directions that will be of benefit in ways we may not even perceive at this point. You never know what you can accomplish until you try!!!

1. Need to evaluate types of future institutes & their areas of concentration, e.g. one like this for people with little experience, others for those with

more experience but particular concerns. 2. All could and should offer CEU credit. 3. Need to arrange library tours for health agencies and public libraries. 4. Bring in State library people to speak and address this issue--put them on the spot. 5. Need to initiate courses in library school; this correlates #1. I greatly appreciate the efforts of Ms. Larson & Ms. Casey we well as the local resource people (Mr. Williams, Ms. Johnson) in conducting this institute. Please do not wait too long to go on to the next venture! One thing leads to another--or could.

Summary

It is apparent from Tables 11 through 13 that several significant changes occurred on the part of participants as a consequence of the institute. These changes related to:

1. The nurse and social worker having greater responsibility for patient/health information dissemination to hospital in-patients and hospital out-patients.
2. The social worker and librarian having greater responsibility for patient/health information dissemination to the general lay public.
3. Less agreement that there is a nationwide effort to develop programs to educate the lay public concerning the right to obtain public information.
4. Less agreement that public librarians are uneasy about providing public health information
5. Greater agreement that the public librarian can assist the public by providing the most reliable, accurate, and up-to-date lay medical material.

It was also shown from the perceptions of the institute and from the written general perceptions that the participants felt the librarian can play a key role in organizing, accessing, supporting, supplying, and interpreting information for the public. The position and responsibility of the librarian, both legally and ethically, was not so clearly defined, although a majority indicated that the responsibility of the librarian, legally and ethically, in the providing and interpreting of information is recognized.

It is apparent from the changed perceptions for the categories "Hospital In-Patients and Out-Patients", "Layperson--General Public", and "General", from the perceptions of the institute, and from the general written perceptions, that the institute did have a significant positive impact on the participants.

DISCUSSION

Miriam T. Larson

When the Institute on Patient/Health Education: The Librarian's Role is looked at as a whole, a composite picture is developed which becomes animate and challenging. The proposals for implementation of the librarian's role, as conceived by the workshop sessions, then become a kind of mirror image of the total complex of the consumer health education need translated into some initial guidelines for action. This melding of multiple viewpoints is brought to both the library and health sciences communities for examination, consideration, and, it is hoped, constructive implementation.

During the discussions, the participants in the Institute expressed these major concerns:

1. Too little is known concerning motivational factors which cause persons to change behavior, yet such knowledge is necessary in order to provide the education which the layman both needs and wants in order to protect and enhance health.

2. There is a general lack of recognition of the librarian as an intrinsic partner in the health care team and as a natural ally in the societal effort to help individuals realize the right to information.

3. Public librarians feel that they are inadequately prepared to provide service to the public in the health care field yet are uncertain as to whether they can turn to health science libraries for support in the more technical areas.

4. Hospital librarians, with a mandate to serve the primary health care team, feel that they may well jeopardize their ability to respond to the needs of that team if the library also accepts the obligation to respond to the needs of the patient and the patient's family.

5. Cooperative arrangements with other health care professionals and health care agencies are needed in order to allow for a more mutual and hence a more effective response to the lay community.

6. The layman may well be ill-prepared to deal with the consequences of receiving certain health information and the potential for misinterpretation may well result in damage to the treatment of the person's health problem.

7. Means do not exist to respond to the currently unserved--the poor, the unlettered, and the culturally unique segments of the population--who do not traditionally use libraries and with whom communication is difficult.

8. There is a lack of reliable and evaluated materials presented in lay terms. It is difficult to select appropriate and valid materials.

9. There is a lack of federal response to the need for supportive services in the specific area of lay health information, particularly in the area of appropriate bibliographic control for the diverse kinds of materials involved.

10. There is a lack of specific financial support for major library efforts in the health education area.

11. The legal liabilities associated with the provision of health information to the public have not been clarified.

12. Library education has not been sufficiently attuned to preparing librarians to serve the health information needs of the general public, either in preservice education or in continuing education.

It became clear during the week-long discussions with resource personnel and within workshop groups that, if librarians are to realize the role which they have to fulfill in the patient/health education effort, the professions will need to:

1. Support and collaborate with the other professions and agencies working for a common goal--a better health status for the individual and for society--and make patent and understandable to everyone involved the library's great potential for contribution to that goal.

2. Establish closer ties and continual dialog between public libraries and health sciences libraries to assure that at no time is the lay individual without access and entry to health education materials, information, and services.

3. Generate ways to gauge the public perception of need in order to make the consumer a partner in the enterprise and not merely a passive recipient.

4. Recognize the enormous diversity of the lay audience in degree of literacy, extent of need, cultural and ethnic background, and language differences, and seek in all ways possible to serve the currently underserved who do not now have natural affiliations with libraries.

5. Define the corpus of information--subject coverage, forms, sources, and extent.

6. Work for the kind of bibliographic and quality control of lay-oriented medical materials, both print and nonprint, which now exist for the information designed for the health professional.

7. Establish a coordinated system which can guarantee dissemination and document delivery and which capitalizes on the expertise existing in the total library community.

8. Promote new and stable financial support to allow for a continuing focus on health information for the public.

9. Seek out those programs which have been initiated, either in libraries or in allied health fields and evaluate the results of such projects in order to profit by their experience.

10. Initiate those activities which will best allow the library's resources to be exploited in a way to allow the individual to use the materials to help himself.

11. Provide more adequate and appropriate pre-service and continuing education design to successfully meet the lay health information demand.

In the last analysis, it may be the intangibles which result from a conference such as this which have the greatest long-term and telling effects: the insights into how other professions and groups working for a common goal, the new and broader perception of problems and opportunities, the increased concern for the public need, and the acceptance of an ethical obligation which is at the very heart of librarianship--the belief that every individual has the inherent right to information and that the librarian is the advocate for that right.

Perhaps, however, the most important insight of the Institute was that consumer health information is a concern of all types of libraries and that all libraries need to work together to provide our communities with the information services needed in this vital area.

The resolution sent by the participants in the Institute to the National Commission on Libraries and Information Science (NCLIS) epitomizes a sense of the involvement which librarianship must have in the health care education need:

> As participants in the Institute on Patient/Health Education: The Librarian's Role . . ., we urge your recognition of consumer health information as an essential element of library service.
>
> All types of libraries, along with health agencies and health care personnel must be involved in this newly delineated area in order to meet the American public's right to health information.
>
> We enlist your support in promoting library participation in the health education movement, in making the role of libraries in the effort known to national, state and local bodies and in securing appropriate funding.
>
> We urge the inclusion of discussions on the health information needs of consumers at the White House Conference on Libraries.

APPENDICES

APPENDIX A

WAYNE STATE UNIVERSITY
COLLEGE OF EDUCATION
DIVISION OF LIBRARY SCIENCE

PATIENT/HEALTH EDUCATION: THE LIBRARIAN'S ROLE

McGregor Conference Center
February 4-9, 1979*

Program

Sunday, February 4, 1979

7:00 p.m.	Registration and Informal Supper: Walter B. Reuther Memorial Archives of Labor and Urban Affairs

Monday, February 5, 1979 (Room G-H)

8:30-9:00 a.m.	Registration
9:00-10:00 a.m.	INTRODUCTION, OBJECTIVES AND PROCEDURES Professor Miriam T. Larson, Institute Director Professor Genevieve M. Casey, Associate Director
10:00-10:20 a.m.	Coffee
10:20-11:45 a.m.	Keynote Address: PATIENT/HEALTH EDUCATION--THE STATE OF THE ART Harold H. Gardner, M.D., Executive Director of Primary Care, Health Care Institute, Wayne State University, Detroit, Michigan
12:00-1:00 p.m.	Lunch
1:00-3:00 p.m.	PATIENT/HEALTH EDUCATION--ISSUES, PROBLEMS, AND OPPORTUNITIES: AN INTERDISCIPLINARY SYMPOSIUM Barbara Coe Johnson, M.S.L.S., Director of Libraries, Harper Hospital Fred M. Whitehouse, M.D., Chief of Metabolism, Henry Ford Hospital Peggy A. Turner, RN, M.S.N., District Director, Visiting Nurse Association of Metropolitan Detroit Betty L. Rusnack, ACSW, Professor, Wayne State University, School of Social Work, Social Work Clinic, Curriculum Coordinator, Health Care Institute, Detroit, Michigan Norman L. Maas, M.S.L.S., Chief of Department, TIP Program, Detroit Public Library James F. Williams II, M.L.S., Medical Librarian, Vera P. Shiffman Medical Library, Wayne State University

3:00-3:20 p.m.	Coffee
3:20-3:30 p.m.	Charge to Workshops--Miriam T. Larson
3:30-5:15 p.m.	Workshop Sessions Group A: Room D Group B: Room E Group C: Room F-1 Resource Persons: James F. Williams II Genevieve M. Casey Miriam T. Larson
5:15-5:30 p.m.	Summary of the Day (Room G-H) Genevieve M. Casey

Tuesday, February 6, 1979 (Room G-H)

9:00-10:10 a.m.	ALTERNATIVE PATTERNS OF COOPERATION/IN A VARIETY OF SETTINGS Genevieve M. Casey, M.L.S., Professor, Division of Library Science, College of Education, Wayne State University Harold M. Schoolman, M.D., Deputy Director for Research and Education, National Library of Medicine John E. Branstetter, M.S.P.H., Area Director of Public Education, American Cancer Society
10:10-10:30 a.m.	Coffee
10:30-12:00 p.m.	Rita M. Lorden, RN, B.S.N., Coordinator, Cardiac Rehabilitation Program, Henry Ford Hospital Eloise C. Foster, M.L., Director, Library of the American Hospital Association, Asa S. Bacon Memorial Library
12:15-1:15 p.m.	Lunch
1:15-5:15 p.m.	Workshop A: Room D Workshop B: Room A Workshop C: Room F-1 (Coffee will be available at 3:15 p.m.)

Wednesday, February 7, 1979

8:45 a.m.	Buses leave from Belcrest Hotel
9:00-12:30 p.m.	Field Observation Wayne State University Shiffman Medical Library/KOM Regional Medical Library

Wayne State University Clinics Building
Harper Hospital Medical Library

12:30-1:30 p.m. Lunch

1:30-3:20 p.m. LIBRARY MATERIALS SUPPORTING PATIENT/HEALTH EDUCATION (Room G-H)
Kathleen M. Carmichael, M.S.L.S., Assistant Librarian, Harper Hospital, Department of Libraries
James F. Williams II, M.L.S., Director, KOM Regional Medical Program
Miriam T. Larson, M.S., MT (ASCP), M.S.L.S., Associate Professor, Division of Library Science, College of Education, Wayne State University

3:20-3:40 p.m. Coffee

3:40-5:30 p.m. Workshop A: Room I
Workshop B: Room A
Workshop C: Room F-1

Thursday, February 8, 1979 (Room J)

9:00-10:10 a.m. LEGAL DIMENSIONS OF PATIENT/HEALTH EDUCATION
Ralph Slovenko, LL.B., Ph.D., Professor of Law and Psychiatry, Wayne State University, School of Law

10:10-10:30 a.m. Coffee

10:30-11:30 a.m. ETHICAL AND SOCIAL DIMENSIONS OF PATIENT/HEALTH EDUCATION
Theodore Goldberg, Ph.D., Chairman and Professor of Community Medicine, School of Medicine, Wayne State University

11:30-12:00 p.m. Summary and Discussion
Genevieve M. Casey, M.L.S., Professor, Division of Library Science, College of Education, Wayne State University

12:15-1:20 p.m. Lunch

1:30-5:00 p.m. Final Workshop Sessions: Completion of Proposals
Group A: Room D
Group B: Room A
Group C: Room I

Friday, February 9, 1979 (Room J)

9:00-12:00 p.m. ESTABLISHING AND MAINTAINING PATIENT/HEALTH RESOURCE CENTERS
Reports of Workshop Groups to Participants

12:00-3:00 p.m. LUNCHEON AND CRITIQUE OF PROPOSALS--DISCUSSION (Room F)
Resource Personnel:
William Leavens, Veterans Administration Hospital Library, Chief
Rita Lorden, Henry Ford Hospital, Patient Education
Norman Maas, Detroit Public Library Referral Center, Chief
Betty Rusnak, School of Social Work, Professor
Peggy Turner, Detroit Visiting Nurse Association, District Director
James Williams II, KOM Regional Medical Library, Director

3:00-3:13 p.m. Evaluation of the Institute
Donald R. Marcotte, Ph.D., Professor, Educational Evaluation and Research, College of Education, Wayne State University

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APPENDIX B

LIST OF PARTICIPANTS

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APPENDIX C

WAYNE STATE UNIVERSITY
DIVISION OF LIBRARY SCIENCE

UNITED STATES OFFICE OF EDUCATION INSTITUTE
PATIENT/HEALTH EDUCATION: THE LIBRARIAN'S ROLE

Questionnaire

PART I. DEMOGRAPHIC INFORMATION

Name_____

Professional Position (Please check the appropriate category):

___Public Administrative Librarian
___Public Reference Librarian
___Hospital Librarian
___University Librarian
___State Medical Librarian
___Library Educator
___State Librarian
___Other (please specify)_____

Years of Experience (Please check the appropriate category):

___Less than 1
___1-5
___6-10
___11-15
___More than 15

Geographic Area (Please check the approariate category):

___Northeast
___Southeast
___Midwest
___Northwest
___Southwest
___Other (please specify)_____

Previous Experience with Patient/Health Education--The Librarian's Role (Please check the appropriate category):

___University Training
___Hospital Training
___Institute
___Other (please specify)_____ _____

Approximate number of volumes in your library (If not applicable, please indicate):_____

PART II. NEEDS

1. Does your library provide health information directly to laymen? (Please check appropriate category)

___On layman's request
___By referral from the physician
___By referral from the nurse
___By referral from social worker
___Other (please specify)_____
_____

2. Are the laymen who seek patient/health inforamtion (Please check the appropriate category):

___Patients in hospital
___Outpatients in hospital
___Families of patients in hospital
___General public

3. Does your library provide health information to laymen? (Please check the appropriate category)

___Directly on request
___At advice of physician
___At advice of nurse
___By request of social worker
___Other (please specify)_____
_____

4. Do you supply printed materials to (Please check the appropriate category):

___Patients directly
___Health information agencies
___Physicians
___Nurses
___Social workers
___Other (please specify)_____
_____

5. Please rank order your major concerns given the areas below. A rank of 1 indicates major concern, whereas a rank of 9 indicates little concern.

___Selection of materials
___Acquisition of materials
___Organization of materials
___Retrieval of materials
___Relationships with health care personnel
___Relationships with voluntary health care associations
___Ethical/Legal dimensions of interpreting information
___Referral of laymen to health care agencies
___Other (please specify)_____
_____

6. Does your library provide materials to support a program of patient health information? ___Yes ___No

PART III. PERCEPTIONS

A four-point scale ranging from Strongly Agree (SA) to Strongly Disagree (SD) will be used for the questions in this section. Please check the space on the scale that you feel represents your position.

Section A. In- and Out-Patient Hospital

1. The physician has a responsibility for patient/health information dissemination. SA SD
2. The nurse has a responsibility for patient/health information dissemination. SA SD
3. The social worker has a responsibility for patient/health information dissemination. SA SD
4. The librarian has a responsibility for patient/health information dissemination. SA SD

Section B. Layperson--General Public

5. The physician has a responsibility for patient/health information dissemination. SA SD
6. The nurse has a responsibility for patient/health information dissemination. SA SD
7. The social worker has a responsibility for patient/health information dissemination. SA SD
8. The librarian has a responsibility for patient/health information dissemination. SA SD

Section C. General

9. There is a nationwide effort to develop programs to educate the lay public concerning the right to obtain public health information. SA SD

10. If a patient has a question concerning health and treatment, the only resource available is his/her physician. SA SD

11. Health information should be provided exclusively for health professionals. SA SD

12. The public librarian can provide a definite service by interpreting public health information to the public. SA SD

13. The librarian plays an important role by being able to assist the patient in interpreting a diagnosis. SA SD

14. The public librarian can assist the public by providing the most reliable, accurate, up-to-date lay medical material. SA SD

15. If the librarian refuses to provide medical information, the individual requesting the information has grounds for legal recourse. SA SD

16. Public librarians are uneasy about providing public health information. SA SD

17. The general lay public is not capable of evaluating health information. SA SD

18. If the librarian provides inaccurate medical information, the individual requesting the has grounds for legal recourse. SA SD

PART IV. GENERAL PERCEPTIONS

If you have perceptions other than those stated in Part III that you think would enhance the evaluation effort, please state them in the space provided below and on the reverse side.

APPENDIX D

UNITED STATES OFFICE OF EDUCATION INSTITUTE
PATIENT/HEALTH EDUCATION: THE LIBRARIAN'S ROLE

Questionnaire

Name_____

PART I. PERCEPTIONS

A four-point scale ranging from Strongly Agree (SA) to Strongly Disagree (SD) will be used for the questions in the following four sections. Please check the space on the scale that you feel represents your position.

Section A. In- and Out-Patient Hospital

1. The physician has a responsibility for patient/health information dissemination. | | | | SA SD
2. The nurse has a responsibility for patient/health inforamtion dissemination. | | | | SA SD
3. The social worker has a responsibility for patient/health information dissemination. | | | | SA SD
4. The librarian has a responsibility for patient/health information dissemination. | | | | SA SD

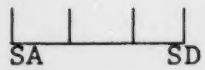
Section B. Layperson--General Public

5. The physician has a responsibility for patient/health information dissemination. | | | | SA SD
6. The nurse has a responsibility for patient/health information dissemination. | | | | SA SD
7. The social worker has a responsibility for patient/health information dissemination. | | | | SA SD
8. The librarian has a responsibility for patient/health information dissemination. | | | | SA SD

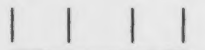
Section C. General

9. There is a nationwide effort to develop programs to educate the lay public concerning the right to obtain public health information. | | | | SA SD

10. If a patient has a question concerning health and treatment, the only resource available is his/her physician.

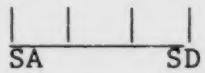


11. Health inforamtion should be provided exclusively for health professionals.

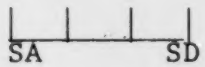


12. The public librarian can provide a definite service by interpreting public health information to the public.

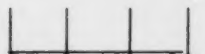
13. The librarian plays an important role by being able to assist the patient in interpreting a diagnosis.



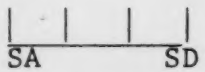
14. The public librarian can assist the public by providing the most reliable, accurate, and up-to-date lay medical material.



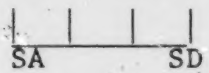
15. If the librarian refuses to provide medical information, the individual requesting the information has grounds for legal recourse.



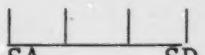
16. Public librarians are uneasy about providing public health information.



17. The general lay public is not capable of evaluating health information.

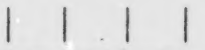


18. If the librarian provides inaccurate medical information, the individual requesting the information has grounds for legal recourse.

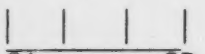


Section D. Institute

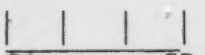
19. The role of the librarian in both supplying and interpreting information to the lay public was clearly distinguished.



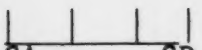
20. Ways in which librarians can participate fruitfully with major deliverers of health information - the physician, the nurse, the social worker, the voluntary associations - were identified.



21. The librarian can support the physician in the interpretation of medical diagnoses, treatment modalities, and prognoses for the patient and for his family, through the provision of access to the lay level informational materials which exist.



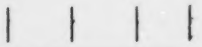
22. The responsibility of the librarian, legally and ethically, in the providing and interpreting of information is recognized.



23. The position of the librarian can be defined both legally and ethically if access to medical information is refused.

24. It is possible to organize a Medical Information Center in such a way as to be responsive to the need for a wide variety of medical information.

25. It is possible to assess the kind and extent of training necessary for the librarian to act as an intermediary in the transfer of health/patient information.



PART II. GENERAL PERCEPTIONS

If you have perceptions other than those stated in Part I that you think would enhance the evaluation effort, please state them in the space provided below and on the reverse side.

APPENDIX E

To the National Commission on Libraries and Information Science

As participants in the Institute on Patient/Health Education: the Librarian's Role held February 5-9, 1979, sponsored by Wayne State University Division of Library Science, and the U.S. Office of Education under Title IIB, Higher Education Act (see attachment), we urge your recognition of consumer health information as an essential element of library service.

All types of libraries, along with health agencies and health care personnel must be involved in this newly delineated area in order to meet the American public's right to health information.

We enlist your support in promoting library participation in the health education movement, in making the role of libraries in the effort known to national, state and local bodies and in securing appropriate funding.

We urge the inclusion of discussions on the health information needs of consumers at the White House Conference on Libraries.

Margaret Duchanchel
Carole Hand
Barbara Ann Johnson
Mary B. Hubbard
Pamela Clark Ross
Kay Denfeld
Christa Schultz

Pamela Kay Dragon
Christine Cammalleri
Holly Shipp Buchanan
Margaret C. Hardy
Phyllis Hlx
Elizabeth Sande
Sara Jean Jackson
Howard A. Epstein
Motta Zaenglein

Christopher Schein
Virginia Mills
Angela Espino-Mazzeo

James F. Williams, II
Theresa Mass
Bill Leavens
Viola A. Bindschaidler
Edward Goodchild
Judith Messerle
Thomas Kyle
Stephanie Ettl
Luella S. Allen

Barbara Bevan
Carl E. Worsteel
Bernard Feeney
Helen Eaton
Dianne Lee Beck
Dave Mindis
Kathleen Mooney